

U.S. DISTRICT COURT
DISTRICT OF VERMONT
FILED

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF VERMONT

2018 DEC -7 AM 10:32

UNITED STATES OF AMERICA,)
Plaintiff,)
)
v.) Civil No.
)
BERNARD FROST,)
Defendant.)

CLERK
BY EM
DEPUTY CLERK

5:18-cv-212

COMPLAINT FOR JUDGMENT ON DEBT

The United States of America, by its attorney, Christina E. Nolan, United States Attorney for the District of Vermont, on behalf of the Social Security Administration, brings this Complaint and states as follows:

1. This is a civil action to obtain a judgment to recover an overpayment of SSA benefits made to the Defendant, Bernard Frost.
2. This Court has jurisdiction in this matter under 28 U.S.C. § 1345 and venue as conferred by 28 U.S.C. § 1391.
3. On information and belief the last known address of the Defendant is follows:

300 Jackson Cross Road
Pownal, VT 05261

4. Defendant, Bernard Frost, (“Defendant”) owes a debt to SSA arising from the overpayment of SSA benefits.

5. Defendant applied for Social Security disability benefits under Titles II and XVI of the Social Security Act on or about July 11, 1990. Exhibit (“Ex.”) A. In the application, defendant agreed to notify SSA if “I GO TO WORK whether as an employee or a self-employed person,” and acknowledged that going to work “may affect [his] eligibility to disability benefits as provided in the Social Security Act, as amended.” Ex. A, at 4 (emphasis in original).

6. Defendant's application for disability benefits also contained the following language:

"I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in connection with this claim is true." *Id.*

7. Based on this application, Defendant became entitled to disability benefits, starting on or about August 1990.

8. While Defendant was collecting disability benefits, he received several notices from SSA showing that work he did affected his benefits, and that he needed to report to SSA any work he performed. For example,

- In August 2005: SSA notice advising Defendant of overpayment due to work activity. Ex. B.
- In April 2006: SSA notice informing Defendant his trial work period ended in June 1999, but he was still eligible for disability benefits because he was not working, or work that he was doing was not substantial. The notice also informed Defendant he must "promptly report" if he "returned to work." Ex. C.
- In May 2006: SSA notice advising Defendant of changes to his disability benefits due to wages he earned. Ex. D.

9. Defendant did not work between October and December 2006, but, in January 2007, he restarted working. Ex. E, at 5-6. Between January 2007 and October 2010, Defendant worked continuously, earning at least \$955.00 per month. *Id.*

10. In February 2007, about two months before his present overpayment started to accrue, SSA conducted a continuing disability review. Ex. F. As part of this review, defendant

conveyed information to SSA about his work activity. Defendant affirmed that he most recently worked at Selective Staffing Solutions between August and September 2006. *Id.*, at 6. SSA again informed Defendant that he was required to report any work he did. *Id.*, at 9-10.

11. Although Defendant had been working since January 2007, and earning \$1,384.50 per month, Ex. E, at 5, he did not report this work to SSA during the continuing disability review conducted in February 2007. Ex. F, at 5-7.

12. Between April 2007 and October 2010, Defendant continued to collect disability benefits, while simultaneously working and earning at least \$955.00 per month. Ex. E, at 5-6. This work made him ineligible for disability benefits, and, in addition, he did not timely report his work to SSA.

13. On May 1, 2009, SSA conducted another continuing disability review, and sent Defendant a form, SSA-821, requesting information about his work. Ex. G. Defendant did not respond to this request.

14. On September 1, 2009, SSA resent Defendant the form asking him for information about his work. *Id.* Defendant responded to this request about two months later, in November 27, 2009. *Id.*

15. Based on the work activity Defendant reported in November 2009, SSA determined he was not eligible for disability benefits between April 2007 and October 2010. Ex. H & I. Defendant accrued an overpayment of disability benefits for this period in the amount of \$34,870.70. *Id.*

16. On or about January 2011, Defendant requested that SSA waive his overpayment. Ex. J.

17. On or about November 2012, SSA issued a waiver determination, where it waived collection of the overpayment defendant accrued between November 2009 and October 2010, but not the overpayment accrued between April 2007 and October 2009. Ex. H & I. The basis for this partial waiver was that Defendant had reported his work to SSA on November 2009, but benefits were not timely stopped due to SSA's delay. Ex. H, at 2.

18. Between April 2007 and October 2009, Defendant was overpaid \$24,323.90. Ex. H. Defendant has since repaid part of this overpayment, and currently owes SSA \$19,664.40. Ex. K.

19. Defendant accrued this overpayment due to work he did, and which he did not report to SSA before November 2009.

20. Defendant knew or should have known that his work activity affected his eligibility to receive disability benefits, yet he worked and received benefits simultaneously, without timely reporting his work to SSA.

21. Defendant knew or should have known that he needed to report any of his work to SSA. Defendant did not report all of his work to SSA.

22. Instead, Defendant withheld information about his work and earnings from SSA, while he received monthly disability benefits from SSA.

23. The disclosure of his work activity to SSA was Defendant's obligation and made him ineligible for disability benefits he received.

24. The Defendant filed a petition under Chapter 7 of the Bankruptcy Code on July 12, 2018. The Plaintiff and the Defendant entered into an agreement to except from discharge the debt owed to the United States in the amount of \$19,664.40 and further agreed that judgment in

this amount would be entered against the Defendant in a subsequently filed lawsuit. *See* Exhibits L and M.

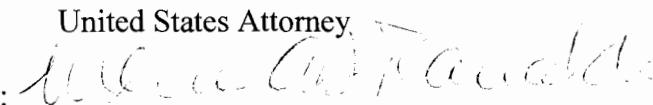
WHEREFORE, the United States demands judgment in its favor in the amount of \$19,664.40 and for such other relief as the Court deems just and appropriate.

Dated at Burlington, in the District of Vermont, this 17 day of December, 2018.

Respectfully submitted,

UNITED STATES OF AMERICA

CHRISTINA E. NOLAN
United States Attorney,

By: 

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Assistant U.S. Attorney
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration TELForm Approved
OMB No. 0960-0960

TOE 120/145

(Do not write in this space)

APPLICATION FOR DISABILITY INSURANCE BENEFITS

I apply for a period of disability and/or all insurance benefits for which I am eligible under title II and part A of title XVIII of the Social Security Act, as presently amended.



PART I—INFORMATION ABOUT THE DISABLED WORKER

1. (a) PRINT your name →	FIRST NAME, MIDDLE INITIAL, LAST NAME <i>Bernard W Frost</i>
(b) Enter your name at birth if different from item (a) →	
(c) Check (✓) whether you are →	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
2. Enter your Social Security Number →	
3. (a) Enter your date of birth →	MONTH, DAY, YEAR <i>1/28/96</i>
(b) Enter name of State or foreign country where you were born. →	<i>Pa Adams Pa</i>

If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 4.

(c) Was a public record of your birth made before you were age 5? →	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
(d) Was a religious record of your birth made before you were age 5? →	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4. (a) What is your disabling condition? (Briefly describe the injury or illness that prevents, or has prevented, you from working.) <i>Alethiasm / stress</i>	
(b) Is your injury or illness related to your work in any way? →	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. (a) When did you become unable to work because of your disabling condition? →	MONTH, DAY, YEAR <i>1/28/96</i>
(b) Are you still disabled? (If "Yes," go on to item 6.) (If "No," answer (c.)) →	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
(c) If you are no longer disabled, enter the date your disability ended. →	MONTH, DAY, YEAR
6. (a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? →	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If "Yes," answer (b) and (c.)) (If "No," or "Unknown" go on to item 7.)
(b) Enter name of person on whose Social Security record you filed other application. →	
(c) Enter Social Security Number of person named in (b). If unknown, check this block. <input type="checkbox"/> →	— / — / —
7. (a) Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968? →	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If "Yes," answer (b) and (c.)) (If "No," go on to item 8.)
(b) Enter dates of service →	FROM: (month, year)
(c) Have you ever been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (Include Veterans Administration benefits only if you waived military retirement pay) →	TO: (month, year)
	<input type="checkbox"/> Yes <input type="checkbox"/> No

8.	(a) Have you filed (or do you intend to file) for any other public disability benefits? (Include workers' compensation and Black Lung benefits)		<input type="checkbox"/> Yes (If "Yes," answer (b).)	<input checked="" type="checkbox"/> No (If "No," go on to item 9.)
	(b) The other public disability benefit(s) you have filed (or intend to file) for is (Check as many as apply):			
	<input type="checkbox"/> Veterans Administration Benefits	<input checked="" type="checkbox"/> Welfare		
	<input checked="" type="checkbox"/> Supplemental Security Income	<input type="checkbox"/> Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)		
9.	(a) Have you ever engaged in work that was covered under the social security system of a country other than the United States? (If "Yes," answer (b).) (If "No," go on to item 10.)		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
	(b) List the country(ies): →			
10.	(a) Are you entitled to, or do you expect to become entitled to, a pension or annuity based on your work after 1956 not covered by Social Security?		<input type="checkbox"/> Yes (If "Yes," answer (b) and (c).)	<input checked="" type="checkbox"/> No (If "No," go on to item 11.)
	(b) <input type="checkbox"/> I became entitled, or expect to become entitled, beginning		MONTH	YEAR
	(c) <input type="checkbox"/> I became eligible, or expect to become eligible, beginning		MONTH	YEAR
I agree to notify the Social Security Administration if I become entitled to a pension or annuity based on my employment after 1956 not covered by Social Security, or if such pension or annuity stops.				
11.	(a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year?		<input checked="" type="checkbox"/> Yes (If "Yes," skip to item 12.)	<input type="checkbox"/> No (If "No," answer (b).)
	(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.			
12.	Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 14.			
	NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer)	Work Began		Work Ended (If still working show "Not ended")
		MONTH	YEAR	MONTH
	<i>RAA Food Service</i>			
	<i>Waverly Fabrics</i>			
	(If you need more space, use "Remarks" space on page 4.)			
13.	May the Social Security Administration or the State agency reviewing your case ask your employers for information needed to process your claim?		<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
14. THIS ITEM MUST BE COMPLETED, EVEN IF YOU WERE AN EMPLOYEE.				
(a) Were you self-employed this year and last year? (If "Yes," answer (b).) (If "No," go on to item 15.) →	<input type="checkbox"/> Yes		<input checked="" type="checkbox"/> No	
(b) Check the year or years in which you were self-employed	In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician)		Were your net earnings from your trade or business \$400 or more? (Check "Yes" or "No")	
<input type="checkbox"/> This Year				
<input type="checkbox"/> Last Year			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Year before last			<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. (a) How much were your total earnings last year? (Count both wages and self-employment income. If none, write "None.") →	Amount \$ _____			
(b) How much have you earned so far this year? (If none, write "None.") →	Amount \$ _____			

(c) Did you receive any money from an employer(s) on or after the date in item 5(a) when you became unable to work because of your disability? (If "Yes," give amounts and explain in "Remarks" on page 4.) →	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
	Amount \$ _____	
(d) Do you expect to receive any additional money from an employer such as sick pay, vacation pay, other special pay? (If "Yes," please give amounts and explain in "Remarks" on page 4.) →	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
	Amount \$ _____	

PART II—INFORMATION ABOUT THE DISABLED WORKER AND SPOUSE

16. Have you ever been married? →	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
(If "Yes," answer item 17.) (If "No," go on to item 18.)			
17. (a) Give the following information about your current marriage. If not currently married, show your last marriage below.			
To whom married	When (Month, day, year)	Where (Name of City and State)	
	10/29/85	NU Wsda	
Your current or last marriage	How marriage ended (If still in effect, write "Not ended.") <i>not ended</i>	When (Month, day, year)	Where (Name of City and State)
	Marriage performed by <input checked="" type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth (or age)	If spouse deceased, give date of death
Spouse's Social Security Number (If none or unknown, so indicate) _____ / _____ / _____			

(b) Give the following information about each of your previous marriages. (If none, write "NONE.")

To whom married	When (Month, day, year)	Where (Name of City and State)	
Your previous marriage	How marriage ended	When (Month, day, year)	Where (Name of City and State)
	Marriage performed by <input type="checkbox"/> Clergyman or public official <input type="checkbox"/> Other (Explain in Remarks)	Spouse's date of birth (or age)	If spouse deceased, give date of death
Spouse's Social Security Number (If none or unknown, so indicate) _____ / _____ / _____			

(Use a separate statement for information about any other marriages.)

18. Have you or your spouse worked in the railroad industry for 7 years or more? →	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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PART III—INFORMATION ABOUT THE DEPENDENTS OF THE DISABLED WORKER

19. If your claim for disability benefits is approved, your children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.
List below: FULL NAME OF ALL such children who are now or were in the past 12 months UNMARRIED and:
<ul style="list-style-type: none"> • UNDER AGE 18 • AGE 18 TO 19 AND ATTENDING SECONDARY SCHOOL • DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)
(IF THERE ARE NO SUCH CHILDREN, WRITE "NONE" BELOW AND GO ON TO ITEM 20.)

20. Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? (If "Yes," enter name and address in "Remarks" on page 4.)	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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**IMPORTANT INFORMATION ABOUT DISABILITY INSURANCE BENEFITS —
PLEASE READ CAREFULLY**

I. SUBMITTING MEDICAL EVIDENCE: I understand that as a claimant for disability benefits, I am responsible for providing medical evidence showing the nature and extent of my disability. I may be asked either to submit the evidence myself or to assist the Social Security Administration in obtaining the evidence. If such evidence is not sufficient to arrive at a determination, I may be requested by the State Disability Determination Service to have an independent examination at the expense of the Social Security Administration.

II. RELEASE OF INFORMATION: I authorize any physician, hospital, agency or other organization to disclose to the Social Security Administration, or to the State Agency that may review my claim or continuing disability, any medical record or other information about my disability.

I also authorize the Social Security Administration to release medical information from my records, only as necessary to process my claim, as follows:

- Copies of medical information may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- The State Vocational Rehabilitation Agency may review any evidence necessary for determining my eligibility for rehabilitative services.

**THIS MUST
BE
ANSWERED**

21. DO YOU UNDERSTAND AND AGREE WITH THE AUTHORIZATIONS GIVEN ABOVE?

Yes No (If "No," explain why in "Remarks.")

22. Check if applicable:

() I am not submitting evidence of the deceased's earnings that are not yet on his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in my benefits will be paid with full retroactivity.

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

*my wife + I are separated. Child I was with her
at 96 Brant Hill North Adams Ma*

III. REPORTING RESPONSIBILITIES: I agree to promptly notify Social Security if:

- My MEDICAL CONDITION IMPROVES so that I would be able to work, even though I have not yet returned to work.
- I GO TO WORK whether as an employee or a self-employed person.
- I apply for or begin to receive a workers' compensation (including black lung benefits) or another public disability benefit, or the amount that I am receiving changes or stops, or I receive a lump-sum settlement.
- I am imprisoned for conviction of a felony.

The above events may affect my eligibility to disability benefits as provided in the Social Security Act, as amended.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

SIGNATURE OF APPLICANT

Signature (First name, middle initial, last name) (Write in ink)

Date (Month, day, year)

SIGN
HERE

Bernard Frost

Telephone Number(s) at which you may be contacted during the day. (Include the area code)

Direct Deposit Payment Address (Financial Institution)			
FOR OFFICIAL USE ONLY	Routing Transit Number	C/S	Depositor Account Number

Applicant's Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)

City and State	ZIP Code	County (if any) in which you now live
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Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

1. Signature of Witness	2. Signature of Witness
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Address (Number and street, City, State and ZIP Code)	Address (Number and street, City, State and ZIP Code)
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**Social Security Administration
Supplemental Security Income**
Notice of Overpayment



SOCIAL SECURITY
3131 SHERIDAN DRIVE
NORTHTOWN BUSINESS CTR
AMHERST, NY 14226
Claim Number: [REDACTED]
August 6, 2005
MIK

BERNARD FROST
[REDACTED]

Dear BERNARD FROST

We are writing to let you know that we have paid you \$724.00 too much Supplemental Security Income (SSI) money. The overpayment happened 11/04-7/05.

SSI did not know that you had been working. Your work effects the amount of SSI you can receive. Your SSI payments were recalculated using your wages and it was determined that you were paid too much in SSI money during that time.

This new overpayment is in addition to the old overpayment of \$31.01 already on your record.

Later in this letter, we'll give you a detailed explanation of your overpayment.

You must pay us back unless we decide you shouldn't have to pay us back or we are wrong about the overpayment. If you think you shouldn't have to pay us back or disagree with the decision about the overpayment, you can:

Ask for a waiver,

Ask for an appeal, or

Do both.

This letter will tell you more about these things you can do.

If We Don't Hear From You In The Next 30 Days

We plan to continue to collect this overpayment from your SSI checks.

Page 2 of 4

If you ask for waiver or appeal in the next 30 days, we won't change your check until we decide the case

If You Think You Shouldn't Have To Pay Us Back

You may not have to pay us back. Sometimes we can waive the collection of an overpayment, which means you won't have to pay us back. For us to waive the collection of your overpayment, two things have to be true.

It wasn't your fault that you got too much SSI money.

AND

Paying us back would mean you can't pay your bills for food, clothing, housing, medical care, or other necessary expenses, or it would be unfair for some other reason.

If you think these are true about you, contact any Social Security office. You can ask for a waiver at any time by completing the waiver form and returning it to us. The form is called Request for Waiver of Recovery or Change in Repayment Rate, Form SSA-632. We will be happy to help you fill out the form. If you ask for waiver in the next 30 days, we will not withhold your payments until we decide if we can waive collection. If you ask for waiver after that time, we will stop collecting the overpayment while we decide if we can waive collection.

If You Disagree With The Decision

If you disagree with the decision, you have the right to appeal. We will review your case and look at any new facts you have.

You have 60 days to ask for an appeal.

The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.

You must have a good reason for waiting more than 60 days to ask for an appeal.

To appeal, you must fill out a form called "Request for Reconsideration." The form number is SSA-561. To get this form, contact one of our offices. We can help you fill out the form.

How To Appeal

There are three ways to appeal. You can pick the one you want. If you meet with us in person, it may help us decide your case.

Case Review . You have a right to review the facts in your file. You can give us more facts to add to your file. Then we will decide your case again. You won't meet with the person who decides your case.

Informal Conference . You'll meet with the person who decides your case. You can tell that person why you think you're right. You can give us more facts to help prove you're right. You can bring other people to help explain your case.

Formal Conference . This is a meeting like an informal conference. The difference is we can make people come to help prove you're right. We can make them bring important papers about your case, even if they don't want to help you. You can question these people at your meeting

If You Want Help With Your Appeal

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

How To Pay Us Back

There are two ways you can pay us back.

As we said earlier, we plan to hold back money from your SSI check. We'll continue to hold back \$60.20 each month until the overpayment is paid back. This is not more than 10 percent of your total income. Ten percent is the most we can hold back without your consent. Contact us if you want a different amount held back.

OR

Another way to pay us back is to send us a check or money order for the full amount of your overpayment of \$724.00. Paying us this way is voluntary . Make the check or money order out to the Social Security Administration. Be sure to put your Social Security number on it. Please use the enclosed envelope to mail the check or money order to us. Also, be sure to enclose the payment stub with your check or money order

Page 4 of 4

If You Receive Social Security Payments

The law allows us to collect the Supplemental Security Income money owed us from Social Security benefits. We can do this when the overpaid person is no longer receiving SSI payments but is receiving Social Security benefits. Before we reduce the Social Security benefit, we will send a notice telling you:

How much the reduction will be; and

When the reduction will begin; and

When you will begin to receive your full regular monthly payment.

If You Have Any Questions

For general information about SSI, visit our website at www.socialsecurity.gov on the Internet. There you will also find the law and regulations about SSI eligibility and SSI payment amounts.

For general questions about SSI or specific questions about your case, you may call us toll-free at 1-800-772-1213 or call your local Social Security office at 716-833-2013 ext 3042. If you call or visit our office, please bring this letter with you and ask for Mrs. Kelly.

Anthony J. Palma Jr.

Anthony J. Palma Jr.
Field Office Manager

Enclosure(s):

**A Detailed Explanation of Overpayment
Payment Stub
Refund Envelope**

A Detailed Explanation Of The Overpayment

Overpayment Summary

We overpaid you \$724.00. The following table shows how your payment changed each month. The first column lists the month(s) we paid you incorrectly. The next column shows the amount we paid you for each month. The last column, Correct Amount for Each Month shows the amount we should have paid you for each month.

Month	Incorrect Amount Paid	Correct Amount Due
November 2004	\$139.00	\$0.00
December 2004	\$139.00	\$81.50
January 2005	\$141.00	\$83.50
February 2005	\$141.00	\$83.50
May 2005	\$141.00	\$0.00
June 2005	\$141.00	\$0.00
July 2005	\$141.00	\$10.50

The SSI we paid you included some payments we made for your State.

Why You Were Overpaid

For the month(s) listed below, the income on our records was wrong. Because we didn't know about all the income, we paid you too much SSI.

11/04 through 7/05

PAYMENTSTUB

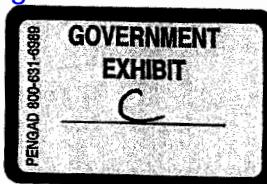
To help us credit your record, please fill out this form and return it with your payment in the enclosed envelope.

NAME: BERNARD W FROST

ACCOUNT NUMBER: XXXXXXXXXX

AMOUNT DUE: \$724.00

ENTER AMOUNT ENCLOSED \$ _____



Social Security Administration Disability Information

Social Security Administration
571 EAST MAIN STREET
BATAVIA NY 14020

Date: April 28, 2006
Claim Number: [REDACTED]

BERNARD FROST III
[REDACTED]

We recently reviewed the evidence in your Social Security disability claim and found that your disability is continuing. Here is some important information about your claim. We have also enclosed information about working that explains some of the terms we use.

You have completed your trial work period. Although you are now working (or have worked and stopped), we find that the work you have been doing does not show that you can do substantial work.

We counted the following as trial work month(s):
October 1998
November 1998
December 1998
January 1999
February 1999
March 1999
April 1999
May 1999
June 1999

Your claim will be reviewed from time to time to see if you are still eligible for benefits based on disability. When your claim is reviewed, you will be contacted if there is any question as to whether your eligibility continues.

If you are receiving Supplemental Security Income payments, any decision about that claim will be sent in a separate notice.

See Next Page

Promptly Report Events Which May Affect Your Benefits

You must promptly report any changes which may affect your benefits. Failure to do so could mean you may have to repay any benefits not due. Let us know if:

- You returned to work since your last report or you return to work in the future (no matter how little you earn); or
- You previously reported your work, but the duties or pay have changed. (Remember to keep records of your work and earnings such as pay statements from your employer.); or
- Your doctor says your condition has improved (even if you do not have a job now); or
- You apply for workers' compensation or another public disability benefit, start receiving those monthly checks (or lump sum), or have a change in the amount; or
- You start paying for work expenses related to your disability (for example, you may require special transportation) or the amount paid for such expenses changes or you no longer pay for such expenses. (Remember to keep proof of payment for any work expenses.)

We will use this information to decide if your health problems still meet our rules or if we must change your payment amount.

If You Disagree With This Decision

If you think we are wrong, you have the right to appeal. We will review your case and consider any new facts you have. A person who did not make the first decision will decide your case.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you receive this letter. We assume you got this letter 5 days after the date on it unless you show us you did not get it within the 5-day period.
- You must have a good reason if you wait more than 60 days to ask for a hearing.
- You have to ask for an appeal in writing. We will ask you to sign a form SSA-561-U2, called "Request for Reconsideration." Contact one of our offices if you want help.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim". It contains more information about the appeal.

If You Want Help With Your Appeal

You can have a friend, representative or someone else help you. There are groups that can help you find a representative or give you free legal services if you qualify. There are also representatives who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

Suspect Social Security Fraud?

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

We invite you to visit our web site at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have specific questions, you may call us toll-free at 1-800-772-1213. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Social Security Administration

Do you want to work but worry about losing your payments or Medicare before you can support yourself? If so, the following information highlights how going back to work may be easier.

Explanation Of The Trial Work Period

In most cases, you can work and earn any amount of money for up to 9 months. (The months do not have to be in a row.) During this time, called a trial work period, you can still get your disability payments. The following information shows how we count the 9 months of the trial work period.

If you are an employee, we only count months you:

- earn over \$620.00 a month beginning in January 2006

- earn over \$590.00 a month beginning in January 2005
- earn over \$580.00 a month beginning in January 2004
- earn over \$570.00 a month beginning in January 2003
- earn over \$560.00 a month beginning in January 2002
- earn over \$530.00 a month beginning in January 2001

If you are self-employed, we only count months you:

- earn over \$620.00 or work more than 80 hours a month beginning in January 2006.
- earn over \$590.00 or work more than 80 hours a month beginning in January 2005.
- earn over \$580.00 or work more than 80 hours a month beginning in January 2004.
- earn over \$570.00 or work more than 80 hours a month beginning in January 2003.
- earn over \$560.00 or work more than 80 hours a month beginning in January 2002.
- earn over \$530.00 or work more than 80 hours a month beginning in January 2001.

Beginning in January 1992, the trial work period is not over until 9 trial work months are completed in a period of 60 months in a row.

Before 1992, you could only have a trial work period the first time you qualified for disability payments. If you qualified for disability payments a second time, usually you could not have a trial work period. Effective January 1992, you can now have a trial work period each time you qualify for disability payments.

After Your Trial Work Period

After we count your 9 trial work months, your right to monthly payments will still continue if you are disabled and your average earnings are not over:

- \$860.00 a month beginning in January 2006.
- \$830.00 a month beginning in January 2005.
- \$810.00 a month beginning in January 2004.
- \$800.00 a month beginning in January 2003.
- \$780.00 a month beginning in January 2002.
- \$740.00 a month beginning in January 2001.

If your average earnings are more than these amounts, we call your work "substantial" and we will stop your monthly payments. (The monthly amounts are higher for Social Security disability benefits due to blindness.)

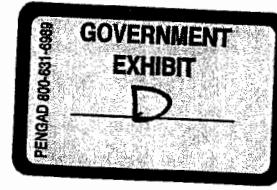
Extended Period of Eligibility

If we must stop your monthly payments after 9 months of trial work, we may still be able to help you. For 36 months after your trial work period ends, we can pay you for any month that you are disabled and your work is not substantial. To get these benefits, you do not have to apply again. Just let us know how much you are earning.

Continuation of Medicare

You can keep your Medicare for at least 93 months after your trial work period ends. Your hospital insurance will be free, but you will still pay for your medical insurance. Beginning in July 1990, you can keep your Medicare after your free hospital insurance coverage ends. But, you must pay a premium for both parts.

**Social Security Administration
Supplemental Security Income
Notice of Change in Payment**



Date: May 1, 2006
Claim Number: [REDACTED]

B98

BERNARD W FROST III
[REDACTED]
[REDACTED]

Type of Payment:
Individual-Disabled

We are writing to tell you about changes in your Supplemental Security Income payments. The following chart shows the SSI money due you for the months we changed. As you can see from the chart, we are only changing your payments for months in the past. The rest of this letter will tell you more about this change.

We explain how we figured the monthly payment amounts shown below on the last pages of this letter. The explanation shows how your income, other than any SSI payments, affects your SSI payment. It also shows how we decided how much of your income affects your payment amount. We include explanations only for months where payment amounts change.

Your Payments Will Be Changed As Follows:

From	Through	Amount Due Each Month
April 1, 2005	April 30, 2005	\$0.00
July 1, 2005	September 30, 2005	\$0.00

Why Your Payments Changed

Because of your income, you were not eligible to receive Supplemental Security Income payments for April 2005 through May 2005 and for July 2005 through September 2005.

Information About Your Payments

This action does not change your current payment amount.

See Next Page

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Your Payment Is Based On These Facts

You had monthly income which must be considered in figuring your eligibility as follows:

- Your Social Security benefits-- before deductions for Medicare premiums, if any-- of \$481.00 for March 2005 through May 2005 and \$481.00 for July 2005 through September 2005.
- Your wages of \$65.00 or less for March 2005, \$792.85 for April 2005, \$846.79 for May 2005, \$1,258.00 for July 2005, \$864.96 for August 2005 and \$952.50 for September 2005.

You Can Review The Information in Your Case

The decisions in this letter are based on the law. You have a right to review and get copies of the information in our records that we used to make the decisions explained in this letter. You also have a right to review and copy the laws, regulations and policy statements used in deciding your case. To do so, please contact us. Our telephone number and address are shown under the heading "If You Have Any Questions."

Things To Remember

- We may be in touch with you later about any payments we previously made.
- This decision refers only to your claim for Supplemental Security Income payments.
- This determination replaces all previous determinations for the above periods.

If You Disagree With The Decision

If you disagree with the decision, you have the right to appeal. A person who hasn't seen your case will look at it. That person will be an Administrative Law Judge. In the rest of our letter we'll call this person an ALJ. The ALJ will correct mistakes and look at any new facts you have before deciding your case. We call this a hearing.

- You have 60 days to ask for a hearing.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You'll have to have a good reason for waiting more than 60 days to ask for a hearing.

05/01/2006

- You have to ask for a hearing in writing. We'll ask you to sign an SSA form HA-501, called "Request for Hearing." Contact one of our offices if you want help.

How A Hearing Works

A hearing works like this.

- The ALJ will tell you the time and place for the hearing.
- The ALJ will explain the law in your case. The ALJ will state the known facts and tell you what has to be decided.
- You can tell the ALJ why you think we're wrong. You can give the ALJ more facts. And you can bring people to say why you're right.
- The ALJ can make people come to your hearing and bring important papers. You can question these people at your hearing.
- We'll ask if you want to go to the hearing in person. If you say you want to go, you should attend if at all possible. If you change your mind or if you can't get to the hearing, you should tell us. You should know that your being there may help the ALJ decide your case.

If You Want Help With Your Hearing

You may want help from a friend, lawyer or someone else. There are groups that can find you a lawyer. Some can give you a free lawyer. We can give you the names of these groups.

If You Have Any Questions

For general information about SSI, visit our website at www.socialsecurity.gov on the Internet. There, you will also find the law and regulations about SSI eligibility and SSI payment amounts.

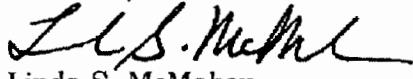
For general questions about SSI or specific questions about your case, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 716-685-3345. Our lines are busiest early in the week and early in the month, so if your business can wait, it's best to call at other times. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
SUITE 13 D
2875 UNION ROAD
CHEEKTOWAGA NY 14227

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If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.


Linda S. McMahon
Deputy Commissioner
for Operations

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HOW WE FIGURED YOUR PAYMENT FOR April 2005**Your Payment Amount**

The most Federal SSI money the law allows us to pay	\$ 579.00
Minus (-) "Total income we count" (see below)	<u>-824.92</u>
Federal SSI money (no Federal payment due because of too much income)	\$ 0.00
The most State SSI money the law allows us to pay	\$ 23.00
Minus (-) remainder of income from State SSI money (\$824.92 minus (-) \$579.00 = \$245.92)	<u>-245.92</u>
State SSI money (no State payment due because of too much income)	\$ 0.00
Total SSI Payment for April 2005	\$ 0.00

Your Income Other Than Your SSI

Income you receive in April 2005 affects your payment for April 2005

Social Security benefits	\$ 481.00	
By law we don't count \$20.00 of above income	<u>- 20.00</u>	
Subtotal of above income we count	\$ 461.00	\$ 461.00
Wages	\$ 792.85	
By law we don't count \$65.00 of wages	<u>- 65.00</u>	
By law we don't count 1/2 of this amount	\$ 727.85	
1/2 of \$727.85 = \$363.93 *	<u>-363.93*</u>	
Subtotal of wages we count	\$ 363.92	<u>+363.92</u>
Total income we count	\$ 824.92	

* beside a number means we have rounded the number

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HOW WE FIGURED YOUR PAYMENT FOR July 2005**Your Payment Amount**

The most Federal SSI money the law allows us to pay	\$ 579.00
Minus (-) "Total income we count" (see below)	<u>-1,057.50</u>
Federal SSI money (no Federal payment due because of too much income)	\$ 0.00
The most State SSI money the law allows us to pay	\$ 23.00
Minus (-) remainder of income from State SSI money (\$1,057.50 minus (-) \$579.00 = \$478.50)	<u>- 478.50</u>
State SSI money (no State payment due because of too much income)	\$ 0.00
Total SSI Payment for July 2005	\$ 0.00

Your Income Other Than Your SSI

Income you receive in July 2005 affects your payment for July 2005

Social Security benefits	\$ 481.00
By law we don't count \$20.00 of above income	<u>- 20.00</u>
Subtotal of above income we count	<u>\$ 461.00</u> \$ 461.00
Wages	\$1,258.00
By law we don't count \$65.00 of wages	<u>- 65.00</u>
By law we don't count 1/2 of this amount	<u>\$1,193.00</u>
1/2 of \$1,193.00 = \$596.50	<u>- 596.50</u>
Subtotal of wages we count	<u>\$ 596.50</u> + 596.50
Total income we count	\$1,057.50

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HOW WE FIGURED YOUR PAYMENT FOR August 2005**Your Payment Amount**

The most Federal SSI money the law allows us to pay	\$579.00
Minus (-) "Total income we count" (see below)	<u>-860.98</u>
Federal SSI money (no Federal payment due because of too much income)	\$ 0.00
The most State SSI money the law allows us to pay	\$ 23.00
Minus (-) remainder of income from State SSI money (\$860.98 minus (-) \$579.00 = \$281.98)	<u>-281.98</u>
State SSI money (no State payment due because of too much income)	\$ 0.00
Total SSI Payment for August 2005	\$ 0.00

Your Income Other Than Your SSI

Income you receive in August 2005 affects your payment for August 2005

Social Security benefits	\$481.00
By law we don't count \$20.00 of above income	<u>- 20.00</u>
Subtotal of above income we count	<u>\$461.00</u> \$461.00
Wages	\$864.96
By law we don't count \$65.00 of wages	<u>- 65.00</u>
By law we don't count 1/2 of this amount	<u>\$799.96</u>
1/2 of \$799.96 = \$399.98	<u>-399.98</u>
Subtotal of wages we count	<u>\$399.98</u> <u>+399.98</u>
Total income we count	\$860.98

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HOW WE FIGURED YOUR PAYMENT FOR September 2005**Your Payment Amount**

The most Federal SSI money the law allows us to pay	\$ 579.00
Minus (-) "Total income we count" (see below)	<u>-904.75</u>
Federal SSI money (no Federal payment due because of too much income)	\$ 0.00
The most State SSI money the law allows us to pay	\$ 23.00
Minus (-) remainder of income from State SSI money (\$904.75 minus (-) \$579.00 = \$325.75)	<u>-325.75</u>
State SSI money (no State payment due because of too much income)	\$ 0.00
Total SSI Payment for September 2005	\$ 0.00

Your Income Other Than Your SSI

Income you receive in September 2005 affects your payment for September 2005

Social Security benefits	\$481.00
By law we don't count \$20.00 of above income	<u>- 20.00</u>
Subtotal of above income we count	<u>\$461.00</u> \$461.00
Wages	\$952.50
By law we don't count \$65.00 of wages	<u>- 65.00</u>
By law we don't count 1/2 of this amount	<u>\$887.50</u>
1/2 of \$887.50 = \$443.75	<u>-443.75</u>
Subtotal of wages we count	<u>\$443.75</u> <u>+443.75</u>
Total income we count	\$904.75

Date: November 01, 2010

CLAIMANT: BERNARD WILLIAM FROST
 SSN: [REDACTED]
 BIC: A



Month	TWP/EPE or EXR	Total Earnings	Countable Earnings	SE Hours	Default SGA	Decision SGA	SGA Override Remark	SGA Override Reason	Decision Event Code	PMT?
02/90		0.00	0.00	0	N	N				N/A
03/90		0.00	0.00	0	N	N				N/A
04/90		0.00	0.00	0	N	N				N/A
05/90		0.00	0.00	0	N	N				N/A
06/90		0.00	0.00	0	N	N				N/A
07/90		0.00	0.00	0	N	N				N/A
08/90	T0	0.00	0.00	0	N	N				Yes
09/90	T0	0.00	0.00	0	N	N				Yes
10/90	T0	0.00	0.00	0	N	N				Yes
11/90	T0	0.00	0.00	0	N	N				Yes
12/90	T0	0.00	0.00	0	N	N				Yes
01/91	T0	0.00	0.00	0	N	N				Yes
02/91	T0	0.00	0.00	0	N	N				Yes
03/91	T0	0.00	0.00	0	N	N				Yes
04/91	T0	0.00	0.00	0	N	N				Yes
05/91	T0	0.00	0.00	0	N	N				Yes
06/91	T0	0.00	0.00	0	N	N				Yes
07/91	T0	0.00	0.00	0	N	N				Yes
08/91	T0	0.00	0.00	0	N	N				Yes
09/91	T0	0.00	0.00	0	N	N				Yes
10/91	T0	0.00	0.00	0	N	N				Yes
11/91	T0	0.00	0.00	0	N	N				Yes
12/91	T0	0.00	0.00	0	N	N				Yes
01/92	T0	0.00	0.00	0	N	N				Yes
02/92	T0	0.00	0.00	0	N	N				Yes
03/92	T0	0.00	0.00	0	N	N				Yes
04/92	T0	0.00	0.00	0	N	N				Yes
05/92	T0	0.00	0.00	0	N	N				Yes
06/92	T0	0.00	0.00	0	N	N				Yes
07/92	T0	0.00	0.00	0	N	N				Yes
08/92	T0	0.00	0.00	0	N	N				Yes
09/92	T0	0.00	0.00	0	N	N				Yes
10/92	T0	0.00	0.00	0	N	N				Yes
11/92	T0	0.00	0.00	0	N	N				Yes
12/92	T0	0.00	0.00	0	N	N				Yes
01/93	T0	0.00	0.00	0	N	N				Yes
02/93	T0	0.00	0.00	0	N	N				Yes
03/93	T0	0.00	0.00	0	N	N				Yes
04/93	T0	0.00	0.00	0	N	N				Yes
05/93	T0	0.00	0.00	0	N	N				Yes
06/93	T0	0.00	0.00	0	N	N				Yes
07/93	T0	0.00	0.00	0	N	N				Yes
08/93	T0	0.00	0.00	0	N	N				Yes
09/93	T0	0.00	0.00	0	N	N				Yes

10/93	T0	0.00	0.00	0	N	N	Yes
11/93	T0	0.00	0.00	0	N	N	Yes
12/93	T0	0.00	0.00	0	N	N	Yes
01/94	T0	0.00	0.00	0	N	N	Yes
02/94	T0	0.00	0.00	0	N	N	Yes
03/94	T0	0.00	0.00	0	N	N	Yes
04/94	T0	0.00	0.00	0	N	N	Yes
05/94	T0	0.00	0.00	0	N	N	Yes
06/94	T0	0.00	0.00	0	N	N	Yes
07/94	T0	0.00	0.00	0	N	N	Yes
08/94	T0	0.00	0.00	0	N	N	Yes
09/94	T0	0.00	0.00	0	N	N	Yes
10/94	T0	0.00	0.00	0	N	N	Yes
11/94	T0	0.00	0.00	0	N	N	Yes
12/94	T0	0.00	0.00	0	N	N	Yes
01/95	T0	0.00	0.00	0	N	N	Yes
02/95	T0	0.00	0.00	0	N	N	Yes
03/95	T0	0.00	0.00	0	N	N	Yes
04/95	T0	0.00	0.00	0	N	N	Yes
05/95	T0	0.00	0.00	0	N	N	Yes
06/95	T0	0.00	0.00	0	N	N	Yes
07/95	T0	0.00	0.00	0	N	N	Yes
08/95	T0	0.00	0.00	0	N	N	Yes
09/95	T0	0.00	0.00	0	N	N	Yes
10/95	T0	0.00	0.00	0	N	N	Yes
11/95	T0	0.00	0.00	0	N	N	Yes
12/95	T0	0.00	0.00	0	N	N	Yes
01/96	T0	0.00	0.00	0	N	N	Yes
02/96	T0	0.00	0.00	0	N	N	Yes
03/96	T0	0.00	0.00	0	N	N	Yes
04/96	T0	0.00	0.00	0	N	N	Yes
05/96	T0	0.00	0.00	0	N	N	Yes
06/96	T0	0.00	0.00	0	N	N	Yes
07/96	T0	0.00	0.00	0	N	N	Yes
08/96	T0	0.00	0.00	0	N	N	Yes
09/96	T0	0.00	0.00	0	N	N	Yes
10/96	T0	0.00	0.00	0	N	N	Yes
11/96	T0	0.00	0.00	0	N	N	Yes
12/96	T0	0.00	0.00	0	N	N	Yes
01/97	T0	0.00	0.00	0	N	N	Yes
02/97	T0	0.00	0.00	0	N	N	Yes
03/97	T0	0.00	0.00	0	N	N	Yes
04/97	T0	0.00	0.00	0	N	N	Yes
05/97	T0	0.00	0.00	0	N	N	Yes
06/97	T0	0.00	0.00	0	N	N	Yes
07/97	T0	0.00	0.00	0	N	N	Yes
08/97	T0	0.00	0.00	0	N	N	Yes
09/97	T0	0.00	0.00	0	N	N	Yes
10/97	T0	0.00	0.00	0	N	N	Yes
11/97	T0	0.00	0.00	0	N	N	Yes
12/97	T0	0.00	0.00	0	N	N	Yes
01/98	T0	0.00	0.00	0	N	N	Yes

02/98	T0	0.00	0.00	0	N	N	Yes
03/98	T0	0.00	0.00	0	N	N	Yes
04/98	T0	0.00	0.00	0	N	N	Yes
05/98	T0	0.00	0.00	0	N	N	Yes
06/98	T0	0.00	0.00	0	N	N	Yes
07/98	T0	0.00	0.00	0	N	N	Yes
08/98	T0	0.00	0.00	0	N	N	Yes
09/98	T0	0.00	0.00	0	N	N	Yes
10/98	T1	576.00	576.00	0	Y	Y	Yes
11/98	T2	768.00	768.00	0	Y	Y	Yes
12/98	T3	960.00	960.00	0	Y	Y	Yes
01/99	T4	768.00	768.00	0	Y	Y	Yes
02/99	T5	768.00	768.00	0	Y	Y	Yes
03/99	T6	768.00	768.00	0	Y	Y	Yes
04/99	T7	1,018.76	1,018.76	0	Y	Y	Yes
05/99	T8	1,513.45	1,513.45	0	Y	Y	Yes
06/99	T9	302.69	302.69	0	N	N	Yes
07/99	E1	0.00	0.00	0	N	N	Yes
08/99	E2	0.00	0.00	0	N	N	Yes
09/99	E3	0.00	0.00	0	N	N	Yes
10/99	E4	0.00	0.00	0	N	N	Yes
11/99	E5	0.00	0.00	0	N	N	Yes
12/99	E6	0.00	0.00	0	N	N	Yes
01/00	E7	0.00	0.00	0	N	N	Yes
02/00	E8	0.00	0.00	0	N	N	Yes
03/00	E9	0.00	0.00	0	N	N	Yes
04/00	E10	0.00	0.00	0	N	N	Yes
05/00	E11	0.00	0.00	0	N	N	Yes
06/00	E12	0.00	0.00	0	N	N	Yes
07/00	E13	0.00	0.00	0	N	N	Yes
08/00	E14	0.00	0.00	0	N	N	Yes
09/00	E15	0.00	0.00	0	N	N	Yes
10/00	E16	0.00	0.00	0	N	N	Yes
11/00	E17	0.00	0.00	0	N	N	Yes
12/00	E18	0.00	0.00	0	N	N	Yes
01/01	E19	0.00	0.00	0	N	N	Yes
02/01	E20	0.00	0.00	0	N	N	Yes
03/01	E21	0.00	0.00	0	N	N	Yes
04/01	E22	0.00	0.00	0	N	N	Yes
05/01	E23	0.00	0.00	0	N	N	Yes
06/01	E24	0.00	0.00	0	N	N	Yes
07/01	E25	0.00	0.00	0	N	N	Yes
08/01	E26	0.00	0.00	0	N	N	Yes
09/01	E27	0.00	0.00	0	N	N	Yes
10/01	E28	0.00	0.00	0	N	N	Yes
11/01	E29	0.00	0.00	0	N	N	Yes
12/01	E30	0.00	0.00	0	N	N	Yes
01/02	E31	0.00	0.00	0	N	N	Yes
02/02	E32	0.00	0.00	0	N	N	Yes
03/02	E33	0.00	0.00	0	N	N	Yes
04/02	E34	0.00	0.00	0	N	N	Yes
05/02	E35	0.00	0.00	0	N	N	Yes

06/02	E36	0.00	0.00	0	N	N		Yes
07/02	E37	0.00	0.00	0	N	N		Yes
08/02	E38	0.00	0.00	0	N	N		Yes
09/02	E39	0.00	0.00	0	N	N		Yes
10/02	E40	0.00	0.00	0	N	N		Yes
11/02	E41	0.00	0.00	0	N	N		Yes
12/02	E42	0.00	0.00	0	N	N		Yes
01/03	E43	0.00	0.00	0	N	N		Yes
02/03	E44	0.00	0.00	0	N	N		Yes
03/03	E45	0.00	0.00	0	N	N		Yes
04/03	E46	0.00	0.00	0	N	N		Yes
05/03	E47	0.00	0.00	0	N	N		Yes
06/03	E48	0.00	0.00	0	N	N		Yes
07/03	E49	0.00	0.00	0	N	N		Yes
08/03	E50	0.00	0.00	0	N	N		Yes
09/03	E51	0.00	0.00	0	N	N		Yes
10/03	E52	0.00	0.00	0	N	N		Yes
11/03	E53	0.00	0.00	0	N	N		Yes
12/03	E54	0.00	0.00	0	N	N		Yes
01/04	E55	0.00	0.00	0	N	N		Yes
02/04	E56	320.00	320.00	0	N	N		Yes
03/04	E57	440.00	440.00	0	N	N		Yes
04/04	E58	439.74	439.74	0	N	N		Yes
05/04	E59	0.00	0.00	0	N	N		Yes
06/04	E60	0.00	0.00	0	N	N		Yes
07/04	E61	0.00	0.00	0	N	N		Yes
08/04	E62	0.00	0.00	0	N	N		Yes
09/04	E63	0.00	0.00	0	N	N		Yes
10/04	E64	0.00	0.00	0	N	N		Yes
11/04	E65	590.00	590.00	0	N	N		Yes
12/04	E66	180.00	180.00	0	N	N		Yes
01/05	E67	0.00	0.00	0	N	N		Yes
02/05	E68	0.00	0.00	0	N	N		Yes
03/05	E69	59.67	59.67	0	N	N		Yes
04/05	E70	792.85	792.85	0	N	N		Yes
05/05	E71	846.79	846.79	0	Y	N	D -- Unsuccessful work attempt not SGA	Yes
06/05	E72	890.00	890.00	0	Y	N	D -- Unsuccessful work attempt not SGA	Yes
07/05	E73	1,258.00	1,258.00	0	Y	N	D -- Unsuccessful work attempt not SGA	Yes
08/05	E74	864.96	864.96	0	Y	N	D -- Unsuccessful work attempt not SGA	Yes
09/05	E75	952.50	952.50	0	Y	N	D -- Unsuccessful work attempt not SGA	Yes
10/05	E76	0.00	0.00	0	N	N		Yes
11/05	E77	0.00	0.00	0	N	N		Yes
12/05	E78	1,956.50	1,956.50	0	Y	N		Yes
01/06	E79	2,064.76	2,064.76	0	Y	N		Yes

02/06	E80	517.33	517.33	0	N	N		Yes
03/06	E81	517.33	517.33	0	N	N		Yes
04/06	E82	0.00	0.00	0	N	N		Yes
05/06	E83	0.00	0.00	0	N	N		Yes
06/06	E84	0.00	0.00	0	N	N		Yes
07/06	E85	0.00	0.00	0	N	N		Yes
08/06	E86	860.92	860.92	0	Y	N	D -- Unsuccessful work attempt not SGA	Yes
09/06	E87	860.92	860.92	0	Y	N	D -- Unsuccessful work attempt not SGA	Yes
10/06	E88	0.00	0.00	0	N	N		Yes
11/06	E89	0.00	0.00	0	N	N		Yes
12/06	E90	0.00	0.00	0	N	N		Yes
01/07	E91	1,384.50	1,384.50	0	Y	Y	C	Yes
02/07	E92	1,384.50	1,384.50	0	Y	Y	G	Yes
03/07	E93	1,384.50	1,384.50	0	Y	Y	G	Yes
04/07	E94	1,384.50	1,384.50	0	Y	Y	B	No
05/07		1,800.50	1,800.50	0	Y	Y		N/A
06/07		955.00	955.00	0	Y	Y		N/A
07/07		955.00	955.00	0	Y	Y		N/A
08/07		955.00	955.00	0	Y	Y		N/A
09/07		955.00	955.00	0	Y	Y		N/A
10/07		955.00	955.00	0	Y	Y		N/A
11/07		955.00	955.00	0	Y	Y		N/A
12/07		955.00	955.00	0	Y	Y		N/A
01/08		2,188.93	2,188.93	0	Y	Y		N/A
02/08		2,188.93	2,188.93	0	Y	Y		N/A
03/08		2,188.93	2,188.93	0	Y	Y		N/A
04/08		2,188.93	2,188.93	0	Y	Y		N/A
05/08		2,188.93	2,188.93	0	Y	Y		N/A
06/08		2,188.93	2,188.93	0	Y	Y		N/A
07/08		2,188.93	2,188.93	0	Y	Y		N/A
08/08		2,188.93	2,188.93	0	Y	Y		N/A
09/08		2,188.93	2,188.93	0	Y	Y		N/A
10/08		2,188.93	2,188.93	0	Y	Y		N/A
11/08		2,188.93	2,188.93	0	Y	Y		N/A
12/08		2,188.93	2,188.93	0	Y	Y		N/A
01/09		1,725.42	1,725.42	0	Y	Y		N/A
02/09		1,725.42	1,725.42	0	Y	Y		N/A
03/09		1,725.42	1,725.42	0	Y	Y		N/A
04/09		1,725.42	1,725.42	0	Y	Y		N/A
05/09		1,725.42	1,725.42	0	Y	Y		N/A
06/09		1,725.42	1,725.42	0	Y	Y		N/A
07/09		1,725.42	1,725.42	0	Y	Y		N/A
08/09		1,725.42	1,725.42	0	Y	Y		N/A
09/09		1,725.42	1,725.42	0	Y	Y		N/A
10/09		1,725.42	1,725.42	0	Y	Y		N/A
11/09		1,725.42	1,725.42	0	Y	Y		N/A
12/09		1,725.42	1,725.42	0	Y	Y		N/A
01/10		2,104.00	2,104.00	0	Y	Y		N/A
02/10		2,104.00	2,104.00	0	Y	Y		N/A

03/10	2,104.00	2,104.00	0	Y	Y	N/A
04/10	2,104.00	2,104.00	0	Y	Y	N/A
05/10	2,104.00	2,104.00	0	Y	Y	N/A
06/10	2,104.00	2,104.00	0	Y	Y	N/A
07/10	2,104.00	2,104.00	0	Y	Y	N/A
08/10	2,104.00	2,104.00	0	Y	Y	N/A
09/10	2,104.00	2,104.00	0	Y	Y	N/A
10/10	2,104.00	2,104.00	0	Y	Y	N/A

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RECIPIENT: [REDACTED] BERNARD W FROST III



BERNARD W FROST III
[REDACTED]

REDETERMINATION SUMMARY FOR DETERMINING CONTINUING ELIGIBILITY
FOR SUPPLEMENTAL SECURITY INCOME PAYMENTS

On February 16, 2007, you provided the following redetermination information to support your continuing eligibility for Supplemental Security Income payments and any federally administered State supplementation under title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under title XIX of the Social Security Act. We have stored your redetermination electronically in our records.

What You Need To Do

- o Review this summary to ensure we recorded your statements correctly.
- o If you agree with all your statements, you should keep this summary for your records.
- o If you disagree with any of your statements, you should contact us within 10 days after the date of this summary to let us know.

o IDENTIFICATION

My name is BERNARD W FROST III. My social security number is [REDACTED].

I am not blind.

I am disabled. My disability began on June 1, 1990.

I was disabled prior to age 22.

I live with [REDACTED]. We do not present ourselves to others as husband and wife.

o FUGITIVE FELON AND PAROLE OR PROBATION VIOLATION INFORMATION

The following statements describe my fugitive felon/parole or probation violator status as of December 1, 2004.

I have not been accused or convicted of a felony or an attempt to commit a felony.

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RECIPIENT: [REDACTED] BERNARD W FROST III

I am not on parole or probation under Federal or State law.

o LIVING ARRANGEMENTS

I have not been outside the United States for a calendar month or 30 consecutive days since December 1, 2004.

I have not spent a calendar month in a hospital, nursing home, correctional facility, or any type of institution since December 1, 2004.

The following statements describe my living arrangements as of July 25, 2004.

I began living at [REDACTED] on July 24, 2004.

I lived in a house/apartment/mobile home/houseboat.

I did not get help or money from any person not living with me or any agency to pay for food, rent, mortgage payments, property insurance, property taxes, heating fuel, gas, electricity, garbage removal, water or sewerage.

The household consisted of the following people:

NAME	RELATIONSHIP	AGE OR BIRTHDATE	BLIND OR DISABLED	MARRIED	STUDENT
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Not all of the people I lived with got public assistance.

I rented the home where I lived. The rent was \$475.00 monthly.

No one in the household was a parent or child of either the landlord or his/her spouse.

I did not eat all of my meals out.

I did not receive any food or shelter from the people I lived with for which I have an agreement to repay.

I did not separately prepare or have someone else separately prepare all of my food.

I did not get a flat fee for room and board from everyone in the household.

All people living in the household were not foster care children, a homemaker provided by the Department of Social Services, or family care recipients placed by the Office of Mental Health/Office of Mental Retardation and Developmental Disabilities or Department of Social Services.

The following statements describe my living arrangements as of October 6, 2005.

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RECIPIENT: [REDACTED] BERNARD W FROST III

I began living at [REDACTED] on October 5, 2005.

I lived in a house/apartment/mobile home/houseboat.

I did not get help or money from any person not living with me or any agency to pay for food, rent, mortgage payments, property insurance, property taxes, heating fuel, gas, electricity, garbage removal, water or sewerage.

The household consisted of the following people:

NAME	RELATIONSHIP	AGE OR BIRTHDATE	BLIND OR DISABLED	MARRIED	STUDENT
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Not all of the people I lived with got public assistance.

I rented the home where I lived. The rent was \$475.00 monthly.

No one in the household was a parent or child of either the landlord or his/her spouse.

I did not receive any food or shelter from the people I lived with for which I have an agreement to repay.

The following statements describe my living arrangements as of March 26, 2006.

I began living at [REDACTED] on March 25, 2006.

I lived in a room in a private home.

My household was separate from the landlord's household.

I did not get help or money from any person not living with me or any agency to pay for food, rent, mortgage payments, property insurance, property taxes, heating fuel, gas, electricity, garbage removal, water or sewerage.

I lived alone.

I rented the home where I lived. The rent was \$120.00 monthly.

No one in the household was a parent or child of either the landlord or his/her spouse.

I did not eat all of my meals out.

I separately prepared or had someone else separately prepare all of my food. MY NAME IS ON ALL OF MY FOOD AND I PREPARE MY OWN MEALS SEPARATELY

The following statements describe my living arrangements as of June 4, 2006.

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RECIPIENT: [REDACTED] BERNARD W FROST III

I began living at [REDACTED] on June 3, 2006.

I live in a room in a private home.

My household is separate from the landlord's household.

I do not get help or money from any person not living with me or any agency to pay for food, rent, mortgage payments, property insurance, property taxes, heating fuel, gas, electricity, garbage removal, water or sewerage.

I live alone.

I rent the home where I live. The rent is \$350.00 monthly.

No one in the household is a parent or child of either the landlord or his/her spouse.

I do not eat all of my meals out.

I separately prepare or have someone else separately prepare all of my food. MY NAME IS ON ALL OF MY FOOD AND I PREPARE MY OWN MEALS SEPARATELY

There have not been any other changes in my living arrangements.

I do not expect these arrangements to change.

REMARKS:

WE DO NOT HOLD OURSELVES OUT TO THE PUBLIC AS MARRIED. WE ARE EXPECTING A CHILD IN 4 MONTHS. WE WILL ADVISE SOCIAL SECURITY WHEN THE BABY IS BORN.

I RENT A BASEMENT 2 ROOM APT W/BATHROOM FROM MY FRIEND, [REDACTED] I USE HIS KITCHEN TO PREPARE MY OWN MEALS SEPARATE FROM HIM. I BUY MY OWN MEALS SEPARATE FROM THEM. I PAY \$120.00 A MONTH RENT INCLUDING UTILITIES. I HAVE MY OWN SEPARATE ENTRANCE. MY HOUSEHOLD IS SEPARATE. I DO NOT TAKE PART IN ANY OF TOM'S HOUSEHOLD DECISIONS. I'D HAVE TO MOVE IF I DID NOT PAY THE RENT.

o RESOURCES

I own the following from February 1, 2007 to continuing:

Truck:

Vehicle: 89 GMC JIMMY

This vehicle is used for transportation.

Value: \$1,000.00 From: December 2003 To: June 2006

Savings account:

Financial institution name: HOOSICK SAVINGS BANK

Value: \$0.84 From: December 2003 To: January 2007

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RECIPIENT: [REDACTED] BERNARD W FROST III

Value: \$5.00 From: February 2007 To: continuing

I do not own any other type of resource.

o INCOME

This report of income is valid for any and all SSI claims in which I am involved.

I receive or expect to receive the following income from December 1, 2004 to continuing:

Social Security:

Amount \$468.00 monthly

From: December 2004 To: December 2004

Amount \$481.00 monthly

From: January 2005 To: December 2005

Amount \$501.00 monthly

From: January 2006 To: November 2006

Amount \$588.00

From: December 2006 To: December 2006

Amount \$607.00 monthly

From: January 2007 To: continuing

Wages:

Amount \$59.67

From: March 2005 To: March 2005

Amount \$271.22

From: April 2005 To: April 2005

Amount \$350.43

From: April 2006 To: April 2006

Employer name: HONEYBAKED HAM CO

Contact: HONEYBAKED HAM CO

Phone: (781) 639-2200

Wages:

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RECIPIENT: [REDACTED] BERNARD W FROST III

Amount \$180.00

From: December 2004 To: December 2004

Employer name: CONSTRUCTIUON PERSONNEL GROUP

Contact: unknown

Phone: unknown

Wages:

Amount \$588.00

From: May 2005 To: May 2005

Amount \$890.00

From: June 2005 To: June 2005

Amount \$1,258.00

From: July 2005 To: July 2005

Employer name: HOME DEPOT

Contact: unknown

Phone: unknown

Wages:

Amount \$304.96

From: August 2005 To: August 2005

Amount _____ * monthly

From: August 2006 To: September 2006

Employer name: SELECTIVE STAFFING SOLUTIONS

Contact: SELECTIVE STAFFING SOLUTIONS

Phone: (716) 634-3300

Wages:

Amount \$521.63

From: April 2005 To: April 2005

Amount \$258.79

From: May 2005 To: May 2005

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RECIPIENT: [REDACTED] BERNARD W FROST III

Employer name: DELTA SONIC CAR WASH

Contact: DELTA SONIC CAR WASH

Phone: (716) 878-9631

Wages:

Amount \$560.00

From: August 2005 To: August 2005

Amount \$952.50

From: September 2005 To: September 2005

Employer name: SNELLING EMPLOYMENT

Contact: SNELLING EMPLOYMENT

Phone: unknown

Wages:

Amount \$1,956.00

From: December 2005 To: December 2005

Amount \$1,197.00

From: January 2006 To: January 2006

Employer name: QUINN CO GENRAL CONTRACTORS

Contact: unknown

Phone: unknown

I do not receive any other type of income.

I do not have work expenses due to a disability.

o ELIGIBILITY FOR OTHER BENEFITS

I currently get food stamps.

o MEDICAID

You may be eligible for Medicaid. However, you must help your State identify other sources that may pay for medical care. Also, you must give information to help the State get medical support for any child(ren) who are your legal responsibility. This includes information to help the State determine who a child's father is.

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RECIPIENT: [REDACTED] BERNARD W FROST III

If you want Medicaid, you must agree to allow your State to seek payments from sources, such as insurance companies, that are available to pay for your medical care. This includes payments for medical care for you or any person who receives Medicaid and is your legal responsibility. The State cannot provide you Medicaid if you do not agree to this Medicaid requirement. If you need further information, you may contact your Medicaid agency.

o MEDICAL ASSISTANCE

I agree that any payments from sources responsible for paying for medical care will go to the State if Medicaid already has paid for this care.

I do not have any private, group or government health insurance that pays the cost of my medical care.

o PERMISSION TO CONTACT FINANCIAL INSTITUTIONS FOR BERNARD W FROST III

We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you notify us in writing that you are canceling your permission, (2) your application for SSI is denied in a final decision, or (3) your eligibility for SSI terminates. If you do not give or cancel your permission you will not be eligible for SSI and we will deny your claim or stop your payments.

I give SSA permission to contact any financial institution and request any financial records that financial institution may have about me.

IMPORTANT REMINDER

Penalty of Perjury

You declared under penalty of perjury that all the information on this summary is true and correct to the best of your knowledge. Anyone who knowingly gives a false or misleading statement about a material fact in a redetermination, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

You must report any change within 10 days after the end of the month it occurs. If you don't, a penalty amount may be deducted from your benefit.

We will check your statements and compare our records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.

If you have a question or something to report, call (____) _____ and ask for [REDACTED]. If you call or visit our office, please have this summary with you. For general information about Social Security, visit our web site at www.socialsecurity.gov on the Internet.

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RECIPIENT: [REDACTED] BERNARD W FROST III

You may come in person or mail your request to the Social Security Office:

SOCIAL SECURITY
SENECA RIDGE PLAZA
3525 SENECA STREET
WEST SENECA NY 14224

REPORTING RESPONSIBILITIES FOR SUPPLEMENTAL SECURITY INCOME

The amount of a Supplemental Security Income check is based on the information told to us. You must report certain changes that happen to you so you continue getting the correct payment amount.

Remember, a change may make the SSI monthly payment bigger or smaller. Report changes in income of your ineligible spouse who lives with you, or your sponsor or sponsor's spouse if you are an alien. You must also report changes in things of value that these people own. Report changes in income, school attendance and marital status of ineligible children who live with you.

You must tell us about any change within 10 days after the month it happens. If you do not report changes, we may have to take as much as \$25, \$50, or \$100 out of future checks.

HOW TO REPORT CHANGES FOR SUPPLEMENTAL SECURITY INCOME

You can make your reports by telephone at the telephone number shown or you may report in person or by mail at the address shown. Always give the Social Security number when writing or telephoning us. If you have any questions, we will be glad to help you. See "Changes to Report for Supplemental Security Income".

CHANGES TO REPORT FOR SUPPLEMENTAL SECURITY INCOME

WHERE YOU LIVE -- You must report to Social Security if:

- o You move.
- o You (or your spouse) leave your household for a calendar month or longer. For example, you enter a hospital or visit a relative.
- o You are no longer a legal resident of the United States.
- o You leave the United States for 30 days or more.
- o You are admitted to, for a calendar month or longer, or released from a hospital, nursing home, prison or other institution.

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RECIPIENT: [REDACTED] BERNARD W FROST III

HOW YOU LIVE -- You must report to Social Security:

- o If someone moves into or out of your household.
- o If the amount of money you pay toward household expenses changes.
- o Births and deaths of any people with whom you live.
- o Your marital status changes:
 - You get married.
 - Your marriage ends in divorce or is annulled.
 - You separate from your spouse or start living together again after a separation.
 - You begin living with someone as husband and wife.
 - Your spouse or former spouse dies.

INCOME -- You must report to Social Security if:

- o The amount of money (or checks or any other type of payment) you receive from someone or someplace goes up or down or you start to receive money (or checks or any other type of payment).
- o You start work or stop work.
- o Your earnings go up or down.
- o You become eligible for benefits other than SSI.

HELP YOU GET FROM OTHERS -- You must report to Social Security if:

- o The amount of help (money, food or payment of household expenses) you receive goes up or down.
- o Someone stops helping you.
- o Someone starts helping you.

THINGS OF VALUE THAT YOU OWN -- You must report to Social Security if:

- o The value of your resources goes over \$2,000 when you add them all together (\$3,000 if you are married and living with your spouse).
- o You sell or give any things of value away.
- o You buy or are given anything of value.

YOU ARE BLIND OR DISABLED -- You must report to Social Security if:

- o Your condition improves or your doctor says you can return to work.
- o You go to work.

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RECIPIENT: [REDACTED] BERNARD W FROST III

IF A WARRANT HAS BEEN ISSUED FOR YOUR ARREST -- You must report to Social Security if:

- o You have a felony warrant for your arrest.
- o You have a Federal or State warrant for a parole or probation violation.

eWork Development Worksheet

Main Menu

Go

Beneficiary Summary

BERNARD W FROST III

Phone: (716) 553-8310

Sex: M

DOB: 10/23/1970

Update Bene Info

Add Payee Info

Query Summary

MBR Information:

Claim Number: [REDACTED]

Terminated

LAF: X7

ADC: 01/07 EBD: 07/99

DOF: 07/15/90 DOED: 08/90

Get Query Details

Get DEQY

Development Summary

Prior Review Completed 10/27/2010

CDR cessation decision

Unit: DE1DJW

Review Period: 05/2006-10/2010

Review Initiated: 05/01/2009

Review Type: Initial

FROST BERNARD WILLIAM

Office: PC7 Unit: DE1DJW

Issue	First Req	Last Req	# Reqs	Tickle Date	Receipt Date	Non Receipt	Issue Remarks	Del	F/U
DUEPROCESS	10/02/2010	10/02/2010	1	10/17/2010	10/27/2010	<input type="checkbox"/>		D	F
SSA-821	05/01/2009	09/01/2009	2	10/30/2009	11/20/2009	<input type="checkbox"/>	REV BEG MON: 05/2006	D	F
SSA-L725	11/29/2006	11/29/2006	1	12/19/2006	12/08/2006	<input type="checkbox"/>	QUINN COMPANY GENERAL CONTRACTOR	D	F
SSA-821	07/13/2006	11/02/2006	3	11/22/2006		<input checked="" type="checkbox"/>	REV BEG MO: 05/2006	D	F

General Remarks:

11/27/2009 821 RETURNED..9 TWPS COMPLETE.CDR FORWARDED TO DE FOR PROCESSING

Cancel

Add New Issue(s)

Save Changes and Stay

Submit and Close

NOV-07-2012 15:07

SSA PORTSMOUTH

603 433 5933 P.002



WAIVER DETERMINATION

1. NUMBER HOLDER Bernard Frost	2. CLAIM NUMBER [REDACTED]
3. PERSON(S) OVERPAID Bernard Frost	
4. TOTAL OVERPAYMENT \$34,870.90	5. MONTHS OF OVERPAYMENT 04/2007-10/2010

6. EXPLANATION OF OVERPAYMENT

The overpayment occurred due to work above SGA levels which resulted in a disability termination. The NH had a work review in 2006 and a continuance. He failed to report any further work activity and a new work CDR was initiated in 2009 due to posted earnings. He completed a work activity report in November 2009 but due to delay benefits were not terminated until November 2010.

7. PERSON(S) LIABLE Bernard Frost		
8.	(a) Recovery of \$10,546.80	waived against Bernard Frost
	(b) This waiver <input checked="" type="checkbox"/> does <input type="checkbox"/> does not bar recovery.	
9.	(a) Recovery of \$24,323.90	not waived against Bernard Frost
	(b) Recovery action for amount not waived: <input type="checkbox"/> Adjustment <input checked="" type="checkbox"/> Refund	
10. WAIVER CONSIDERATION		
(a) Type of overpayment <input type="checkbox"/> Deduction <input type="checkbox"/> Entitlement		(b) waiver code <input type="checkbox"/> Ded. O/P <input type="checkbox"/> Ent. O/P

NOV-07-2012 15:07

SSA PORTSMOUTH

603 433 5933 P.003

11. (a) Person(s) listed is at fault / without fault because:

(Note: Discuss separately if at fault for part of overpayment and without fault for part.)

The NH failed to report further work activity even though he had just had a work review. However I am finding he is not at fault for the period 11/2009 through 10/2010 after he had completed the work activity report because we delayed terminating his benefits even though we had sufficient information.

11. (b) Recovery would / would not defeat the purpose of Title II or would / would not be against equity and good conscience because:

He cannot afford to repay, he is no longer working and has just filed for T2 and SSI.

12. Based on these facts and conclusions under Section 204 (b) of the Social Security Act and Regulations No. 4,404.508-404.512 (or Section 1870 (c) of the Social Security Act and Regulation No. 5, 405.355-404.356), we find that

Recovery of the overpayment from person(s) listed in item 8 should be waived.
 Recovery of the overpayment from person(s) listed in item 9 should not be waived.

DETERMINATION PREPARED/APPROVED BY Barbara Barreiro	TITLE TE	DATE 11-06-2012
APPROVED BY <i>Jeremy Gauthier</i>	TITLE <i>CR</i>	DATE <i>11/7/2012</i>
APPROVED BY	TITLE	DATE
APPROVED BY	TITLE	DATE



**Social Security Administration
Retirement, Survivors and Disability Insurance**
Overpayment Information

SOCIAL SECURITY
PO BOX 209
PORTSMOUTH, NH 03802-9927
Date: November 06, 2012
Claim Number: [REDACTED]
BAB

BERNARD W. FROST III
[REDACTED]

Dear BERNARD W. FROST III

We are writing about your request that we waive the collection of your Social Security overpayment. Based on the facts we have, we will waive the collection of part of your Social Security overpayment of \$34,870.70. You will not have to pay back \$10,546.80 of this overpayment. However, this means that you still have to pay back \$24,323.90 of this overpayment.

Below, we explain why we cannot waive collection of all of your overpayment.

The Reason For Our Decision

For us to waive the collection of all of your overpayment, two things have to be true.

- It was not your fault that you got too much Social Security money.
AND
- Paying us back would mean you cannot pay your bills for food, clothing, housing, medical care, or other necessary expenses, or it would be unfair for some other reason.

Based on the facts we have, you do not meet both of these rules.
The following will tell you why.

We find that you are at fault for the overpayment for April 2007 through October 2009. The overpayment occurred due to your work which was above the substantial gainful activity limits. Even though you had just had a work review in 2006, you did not report your work activity in 2007.

See Next Page

We apply three tests when we decide if you are at fault in causing an overpayment. The first is whether you made an incorrect statement or a statement which you knew or should have known was incorrect. The second is whether you failed to give us timely information which you knew or should have known was important. The third is whether you accepted payments which you either knew or could have been expected to know were incorrect.

You had been informed of your reporting responsibilities and the effects that work activity has on your receipt of Social Security benefits in 2006. You failed to report your subsequent work activity.

Therefore, based on the facts we have, we cannot waive the collection of \$24,323.90 of this overpayment. This means that you must pay this money back.

If You Disagree With The Decision

If you disagree with this decision, you have the right to appeal. A person who has not seen your case before will look at it. That person will be an administrative law judge. The administrative law judge will review your case and look at any new facts you have before deciding your case. We call this a hearing.

- You have 60 days to ask for a hearing.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You will have to have a good reason for waiting more than 60 days to ask for a hearing.

You have to ask for a hearing in writing. We will ask you to sign an SSA form HA-501, called "Request for Hearing." Contact one of our offices if you want help.

If You Want Help With Your Hearing

You can have a friend, representative or someone else help you. There are groups that can help you find a representative or give you free legal services if you qualify. There also are representatives who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a representative who is eligible for direct pay, we will withhold up to 25 percent of any past due benefits to pay toward the fee.

[REDACTED] Page 3 of 3

If You Have Questions

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social

Security office at 888-397-9796. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
ROOM 210A
80 DANIEL ST
PORTSMOUTH, NH 03801-0209

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Social Security Administration

NOV-07-2012 15:09

SSA PORTSMOUTH

603 433 5933

**GOVERNMENT
EXHIBIT**

SOCIAL SECURITY ADMINISTRATION

Request For Waiver Of Overpayment Recovery Or Change In Repayment Rate

We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we can't waive collection, we may use this form to decide how you should repay the money.

Please answer the questions on this form as completely as you can. We will help you fill out the form if you want. If you are filling out this form for someone else, answer the questions as they apply to that person.

FOR SSA USE ONLY

ROAR Input Yes

□ No

Input Date

Waiver Approval

□ Statistics

SSI 口 Yes 口 No

AMT OF OFS 24/02/2020

PERIOD (DATES) OF OP.

“બ્રહ્મ” ॥ ૧૦

1. A. Name of person on whose record the overpayment occurred:

B. Social Security Number

C. Name of overpaid person(s) making this request and his/her Social Security Number(s):

Bernard Frost

Social Security Number(s):
[REDACTED]

2 Check any of the following that apply. (Also, fill in the dollar amount in B, C, or D.)

A. The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reasons.

B. I cannot afford to use all of my monthly benefit to pay back the overpayment. However I can afford to have \$ _____ withheld each month.

C. I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back \$ _____ each month instead of paying all of the money at once.

D. I am receiving SSI payments. I want to pay back \$ _____ each month instead of paying 10% of my total income.

NOV-07-2012 15:09

SSA PORTSMOUTH

603 433 5933 P.009

SECTION I: INFORMATION ABOUT RECEIVING THE OVERPAYMENT

3. A. Did you, as representative payee, receive the overpaid benefits to use for the beneficiary?

Yes No (Skip to Question 4)

B. Name and address of the beneficiary

C. How were the overpaid benefits used?

4. If we are asking you to repay someone else's overpayment:

A. Was the overpaid person living with you when he/she was overpaid?

Yes No

B. Did you receive any of the overpaid money?

Yes No

C. Explain what you know about the overpayment AND why it was not your fault.

5. Why did you think you were due the overpaid money and why do you think you were not at fault in causing the overpayment or accepting the money?

Never noticed of a long period was up 3 years ago monthly payments received. Social Security knew I was working when my SSE had stopped

6. A. Did you tell us about the change or event that made you overpaid? If no, why didn't you tell us?

Yes No

B. If yes, how, when and where did you tell us? If you told us by phone or in-person, who did you talk with and what was said?

Since a year for the past 3 years at the over a year review

C. If you did not hear from us after your report, and/or your benefits did not change, did you contact us again?

Yes No

By letter

7. A. Have we ever overpaid you before?

Yes No

If yes, on what Social Security number?

[REDACTED]

B. Why were you overpaid before? If the reason is similar to why you are overpaid now, explain what you did to try to prevent the present overpayment.

Small amt SS says was overpaid with held from payments from SSA

NOV-07-2012 15:09

SSA PORTSMOUTH

603 433 5933 P.010

SECTION II-YOUR FINANCIAL STATEMENT

NAME: _____

SSN: _____

You need to complete this section if you are asking us either to waive the collection of the overpayment or to change the rate at which we asked you to repay it. Please answer all questions as fully and as carefully as possible. We may ask to see some documents to support your statements, so you should have them with you when you visit our office.

EXAMPLES ARE:

- Current Rent or Mortgage Books
- Savings Passbooks
- Pay Stubs
- Your most recent Tax Return
- 2 or 3 recent utility, medical, charge card, and insurance bills
- Cancelled checks
- Similar documents for your spouse or dependent family members

Please write only whole dollar amounts-round any cents to the nearest dollar. If you need more space for answers, use the "Remarks" section at the bottom of page 7.

8. A. Do you now have any of the overpaid checks or money in your possession (or in a savings or other type of account)?

Yes Amount\$ _____
Return this amount to SSA

No

B. Did you have any of the overpaid checks or money in your possession (or in a savings or other type of account) at the time you received the overpayment notice?

Yes Amount\$ _____
Answer Question 9.

No

9. Explain why you believe you should not have to return this amount.

*not working, IT will be a financial hard ship. Had to move
by myself and I with family so I can get to work and
make my car payment.*

ANSWER 10 AND 11 ONLY IF THE OVERPAYMENT IS SUPPLEMENTAL SECURITY INCOME (SSI) PAYMENTS. IF NOT, SKIP TO 12.

10. A. Did you lend or give away any property or cash after notification of the overpayment?

Yes (Answer Part B)

B. Who received it, relationship (if any), description and value:

No (Go to question 11.)

11. A. Did you receive or sell any property or receive any cash (other than earnings) after notification of this overpayment?

Yes (Answer Part B)

B. Describe property and sale price or amount of cash received:

No (Go to Question 12.)

12. A. Are you now receiving cash public assistance such as Supplemental Security Income (SSI) payments?

Yes (Answer B and C and See note below)

No

C. Claim Number

IMPORTANT: If you answered "YES" to question 12, DO NOT answer any more questions on this form. Go to page 8, sign and date the form, and give your address and phone number(s). Bring or mail any papers that show you receive public assistance to your local Social Security office as soon as possible.

NOV-07-2012 15:10

SSA PORTSMOUTH

603 433 5933 P.011

Members Of Household

13. List any person (child, parent, friend, etc.) who depends on you for support AND who lives with you.

NAME	AGE	RELATIONSHIP (If none, explain why the person is dependent on you)

Assets-Things You Have And Own

14. A. How much money do you and any person(s) listed in question 13 above have as cash on hand, in a checking account, or otherwise readily available?

B. Does your name, or that of any other member of your household appear, either alone or with any other person, on any of the following?

\$ 20.00

TYPE OF ASSET	OWNER	BALANCE OR VALUE	SHOW THE INCOME (Interest, dividends) EARNED EACH MONTH. (If none explain in spaces below. If paid quarterly, divide by 3.)	
			PER MONTH	
SAVINGS (Bank, Savings and Loan, Credit Union)		\$	\$	
		\$	\$	
CERTIFICATES OF DEPOSIT (CD)		\$	\$	
INDIVIDUAL RETIREMENT ACCOUNT (IRA)		\$	\$	
MONEY OR MUTUAL FUNDS		\$	\$	
BONDS, STOCKS		\$	\$	
TRUST FUND		\$	\$	
CHECKING ACCOUNT		\$ 100	\$	
OTHER (EXPLAIN)		\$	\$	
TOTALS —		\$ 100	\$	Enter the "Per Month" total on the (K) of question 10.

15. A. If you or a member of your household own a car, (other than the family vehicle), van, truck, camper, motorcycle, or any other vehicle or a boat, list below.

OWNER	YEAR/MAKE/MODEL	PRESENT VALUE	LOAN BALANCE (if any)	MAIN PURPOSE FOR USE
ESTATE FUND	05 Chevy Imp	\$ 8000.00	\$ 2000	WORK DUTIES INC
		\$	\$	
		\$	\$	

B. If you or a member of your household own any real estate (buildings or land), OTHER than where you live, or own or have an interest in, any business, property, or valuables, describe below.

OWNER	DESCRIPTION	MARKET VALUE	LOAN BALANCE (if any)	USAGE-INCOME (rent etc.)
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

NOV-07-2012 15:10

SSA PORTSMOUTH

603 433 5933 P.012

Monthly Household Income

If paid weekly, multiply by 4.33 (4 1/3) to figure monthly pay. If paid every 2 weeks, multiply by 2.166 (2 1/6). If self-employed, enter 1/12 of net earnings. Enter monthly TAKE HOME amounts on the A of question 18 also.

16. A. Are you employed? YES (Provide information below) NO (Skip to B)

Employer name, address, and phone: (Write "self" if self-employed)
Self employment

Monthly pay before deduction (Gross)	\$ 850
Monthly TAKE-HOME pay (NET)	\$ 550

B. Is your spouse employed? YES (Provide information below) NO (Skip to C)

Employer(s) name, address, and phone: (Write "self" if self-employed)

Monthly pay before deduction (Gross)	\$
Monthly TAKE-HOME pay (NET)	\$

C. Is any other person listed in Question 13 employed? YES Name(s)
 NOT (Go to Question 17)

Employer(s) name, address, and phone: (Write "self" if self-employed)

Monthly pay before deduction (Gross)	\$
Monthly TAKE-HOME pay (NET)	\$

17. A. Do you, your spouse or any dependent member of your household receive support or contributions from any person or organization? YES (Answer B) NO (Go to question 18)

B. How much money is received each month? \$ **SOURCE**

BE SURE TO SHOW MONTHLY AMOUNTS BELOW - If received weekly or every 2 weeks, read the instruction at the top of this page.

18. INCOME FROM #16 AND #17 ABOVE AND OTHER INCOME TO YOUR HOUSEHOLD		YOURS	<input checked="" type="checkbox"/>	SPOUSE'S	<input checked="" type="checkbox"/>	OTHER HOUSEHOLD MEMBERS	<input checked="" type="checkbox"/>	SSA USE ONLY
A. TAKE HOME Pay (Net) (From #16 A, B, C, above)		\$	<input type="checkbox"/>	\$	<input type="checkbox"/>	\$	<input type="checkbox"/>	
B. Social Security Benefits		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
C. Supplemental Security Income (SSI)		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
D. Pension(s) (VA, Military, Civil Service, Railroad, etc.)	TYPE		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
	TYPE		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
E. Public Assistance (Other than SSI)		TYPE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
F. Food Stamps (Show full face value of stamps received)			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
G. Income from real estate (rent, etc.) (From question 15B)			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
H. Room and/or Board Payments (Explain in remarks below)			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
I. Child Support/Alimony			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
J. Other Support (From #17 (E) above)			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
K. Income From Assets (From question 14)			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
L. Other (From any source, explain below)			<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
REMARKS	TOTALS	\$		\$		\$		
					GRAND TOTAL	\$	0.00	(Add 3 totals blocks above)

NOV-07-2012 15:10

SSA PORTSMOUTH

603 433 5933 P.013

Monthly Household Expenses

If the expense is paid weekly or every 2 weeks, read the instruction at the top of Page 5. Do NOT list an expense that is withheld from income (Such as Medical Insurance). Only take home pay is used to figure income.

Show "CC" as the expense amount if the expense (such as clothing) is part of CREDIT CARD EXPENSE SHOWN ON LINE (F).

	\$ PER MONTH	SSA USE ONLY
19. A. Rent or Mortgage (If mortgage payment includes property or other local taxes, insurance, etc. DO NOT list again below.)	300.00	
B. Food (Groceries (Include the value of food stamps) and food at restaurants, work, etc.)	300.00	
C. Utilities (Gas, electric, telephone)	60	
D. Other Heating/Cooking Fuel (Oil, propane, coal, wood, etc.)	—	
E. Clothing	—	
F. Credit Card Payments (show minimum monthly payment allowed)	50.00	
G. Property Tax (State and local)	—	
H. Other taxes or fees related to your home (trash collection, water-sewer fees)	—	
I. Insurance (Life, health, fire, homeowner, renter, car, and any other casualty or liability policies)	165.00	
J. Medical-Dental (After amount, if any, paid by insurance)	—	
K. Car operation and maintenance (Show any car loan payment in (N) below)	355.20	
L. Other transportation	—	
M. Church-charity cash donations	—	
N. Loan, credit, lay-away payments (If payment amount is optional, show minimum)	—	
O. Support to someone NOT in household (Show name, age, relationship (if any) and address)	—	
P. Any expense not shown above (Specify)	—	
EXPENSE REMARKS (Also explain any unusual or very large expenses, such as medical, college, etc.)	TOTAL	\$ 6010.20

NOV-07-2012 15:11

SSA PORTSMOUTH

603 433 5933

P.014

P.UUB

Income And Expenses Comparison

20. A. Monthly income (Write the amount here from the "Grand Total" of #18.)	→	\$ 0
B. Monthly Expenses (Write the amount here from the "Total" of #19.)	→	\$ 10.26
C. Adjusted Household Expenses	→	+ \$25
D. Adjusted Monthly Expenses (Add (B) and (C))	→	\$ 10.35 ²⁴

21. If your expenses (D) are more than your income (A), explain how you are paying your bills.

FOR SSA USE ONLY	
<input type="checkbox"/> INC. EXCEEDS	\$
<input type="checkbox"/> ADJ. EXPENSE	+
<input type="checkbox"/> INC. LESS THAN	\$
<input type="checkbox"/> ADJ. EXPENSE	-

Help From FamilyFinancial Expectation And Funds Availability

22. A. Do you, your spouse or any dependent member of your household expect your or their financial situation to change (for the better or worse) in the next 6 months? (For example: a tax refund, pay raise or full repayment of a current bill for the better-major house repairs for the worse).

YES (Explain on line below)
 NO

Friend of Clark

B. If there is an amount of cash on hand or in checking accounts shown in Item 14A, is it being held for a special purpose?

NO (Amount on hand)
 NO (Money available for any use)
 YES (Explain on line below)

Car part, ITNSurance, Food, ETC

C. Is there any reason you CANNOT convert to cash the "Balance or Value" of any financial asset shown in Item 14B.

YES (Explain on line below)
 NO

D. Is there any reason you CANNOT SELL or otherwise convert to cash any of the assets shown in items 16A and B?

YES (Explain on line below)
 NO

Remarks Space -

If you are continuing an answer to a question, please write the number (and letter, if any) of the question first.

AFTER ONLY RECEIVING A 10 DAY NOTICE THAT SSDI WAS STOPPED
IT did not give me enough time to move up that extra time
needed for Rent and car part. So there was no choice but to move
in with Family with my 2yr daughter. For Help until I get
back on my feet when I do get back on my feet
I wouldn't make enough to pay this amount BACK (MORE SPACE ON NEXT PAGE)

NOV-07-2012 15:11

SSA PORTSMOUTH

603 433 5933

P.015

REMARKS SPACE (Continued)

I have reported work during all reviews for the past 4 years as my SE. That first my SST does stop due to lack.

PENALTY CLAUSE, CERTIFICATION AND PRIVACY ACT STATEMENT

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE OF OVERPAID PERSON OR REPRESENTATIVE PAYEE

SIGNATURE (First name, middle initial, last name) (Write in ink)

DATE (Month, Day, Year)

10-23-70

HOME TELEPHONE NUMBER (include area code)

(802) 733-3024

WORK TELEPHONE NUMBER IF WE MAY CALL YOU AT WORK (include area code)

(-)

SIGN
HERE

MAILING ADDRESS (Number and street, Apt. No., P.O. Box, or Rural Route)

108 Spring Street

CITY AND STATE:

Brimmington VT

ZIP CODE

05201 -

ENTER NAME OF COUNTY (IF ANY) IN WHICH YOU NOW LIVE

Brimmington

Witnesses (Required ONLY if this statement has been signed by mark (X) above. If signed by mark (O), two witnesses to the signing who know the individual must sign below, giving their full addresses.)

SIGNATURE OF WITNESS

SIGNATURE OF WITNESS

ADDRESS (Number and street, City, State, and ZIP Code)

ADDRESS (Number and street, City, State, and ZIP Code)

Privacy Act Statement

To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs; and To the Department of Justice when representing the Social Security Administration in litigation.

Sections 204, 1631(b), and 1870 of the Social Security Act, as amended, and the Federal Coal Mine Health and Safety Act of 1969 authorize us to collect this information. The information you provide will be used to make a determination on whether overpayment recovery or changing your repayment rate.

The information you furnish on this form is voluntary. However, failure to provide the requested information may prevent us from approving your request.

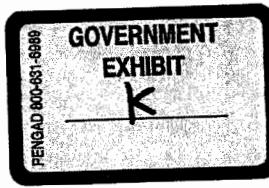
We rarely use the information you supply for any purpose other than for determining waiver or a change in the repayment rate of an overpayment recovery. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.ssa.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 hours to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** To find the nearest office, call 1-800-772-1213 (TTY 1-800-325-0778). Send only comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21233-0401.



Social Security Administration

Billing Statement

Important Information

Northeastern Program Service Center
1 Jamaica Center Plaza
Jamaica, New York 11432-3898
Date: June 27, 2018
[REDACTED]

|||||...|||||
BERNARD W FROST III
[REDACTED]

AMOUNT DUE	\$200.00
Balance From Previous Statement	\$19,664.40
New Balance	\$19,664.40

PAYMENT OF NEW BALANCE OR AMOUNT DUE
MUST REACH US BY July 15, 2018

Did You Forget?

This statement concerns an overpayment of Social Security benefits paid to
BERNARD W FROST, A.

We have not received the \$100.00 payment that was due by June 15, 2018. Please
send us the full payment right away.

To request to repay a smaller amount monthly over a longer period of time, please
call us at the telephone number below.

If you have mailed the past due amount of \$100.00 within the past week, you should
only make this month's payment of \$100.00.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <http://oig.ssa.gov/report> or call the
Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

If you have any questions about this statement, please call us at 1-888-280-9419
TOLL-FREE. The office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.
ET.

[REDACTED] Page 2 of 4

If you call us using a TDD machine, please pause after you type a few words. This will give us time to transfer your call to the TDD line.

Social Security Administration

Enclosure(s):
Refund Env.

PAYMENT STUB

- Return the bottom portion of the stub with your payment.
- Use the enclosed envelope to mail your payment to us.
- Do not send cash.
- Do not enclose any correspondence with your remittance. Send any correspondence to: Social Security Administration, Northeastern Program Service Center, PO Box 314400, Jamaica NY 11431-9887.
- If you have changed your address or telephone number, be sure to check the box below and write your new address or telephone number in the space provided.
- If you pay by check or money order, include your Social Security Claim Number and make the check or money order payable to "Social Security Administration."
- If paying by credit card, complete the appropriate information below and return it in the enclosed envelope

OR

to pay by phone, call 1-888-280-9419 TOLL-FREE during the hours 8:00 a.m. to 5:00 p.m. ET. Please have this notice and your credit card available when you call.

SSA-53-EP

DETACH HERE. DO NOT STAPLE.

AMOUNT DUE: \$200.00
DATE DUE: July 15, 2018

PAYMENT
AMOUNT: \$_____

Check box if your address or
telephone number has changed.
Make changes below.

MASTERCARD VISA DISCOVER

Credit Card Number

Exp Date

Cardholder's Signature

Date

SOCIAL SECURITY ADMINISTRATION
PO BOX 3430
PHILADELPHIA PA 19122-9985

Privacy Act Statement

The Social Security Administration (SSA) has authority to collect the information requested on the PAYMENT STUB under section 204 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. This will allow you to repay your overpayment with your credit card. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security office.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.



UNITED STATES BANKRUPTCY COURT
FOR THE
DISTRICT OF VERMONT

In Re:)	
)	Bankruptcy No. 18-10289-cab
BERNARD FROST,)	Chapter 7
Debtor.)	
UNITED STATES OF AMERICA,)	
)	Adversary No. 18-01005-cab
Plaintiff,)	
v.)	
BERNARD FROST,)	
)	
Defendant.)	

**STIPULATION FOR CONSENSUAL SETTLEMENT OF
NON-DISCHARGEABILITY DISPUTE**

The United States of America, by its attorney, Christina E. Nolan, United States Attorney for the District of Vermont, on behalf of the United States Social Security Administration (“SSA”), and Bernard Frost, the Debtor, by his attorney, Rebecca A. Rice, Esq., hereby enter into the following stipulation for resolution of issues concerning dischargeability of the Debtor’s debt to the SSA.

Recitals

WHEREAS, SSA alleges that the Debtor owes SSA a debt in the amount of \$19,664.40 as of the petition-date for an overpayment of Social Security benefits;

WHEREAS, the Debtor’s schedule F lists the debt owed to SSA as an Unsecured Nonpriority Claim, but asserts the amount owed is \$19,664.00;

WHEREAS, the Debtor does not dispute the amount owed to SSA is \$19,664.40;

WHEREAS, the Debtor admits that he knew or should have known that he was required to report any changes in his earnings or earnings estimates to SSA;

WHEREAS, the Debtor admits that he did not report changes in such earnings or earnings estimates;

WHEREAS, the Debtor's failure to report changes in his earnings and earnings estimates caused the overpayment of SSA benefits;

WHEREAS, the Debtor admits that SSA could establish that the full amount of the claimed overpayment would be excepted from discharge pursuant to 11 U.S.C. § 523(a)(2)(A); and

WHEREAS, the Debtor and SSA now seek to resolve their dispute amicably and without resort to further litigation:

Agreement

NOW THEREFORE, the Debtor and SSA agree as follows:

1. The Debtor admits and agrees that SSA would be able to establish that he knew or should have known that he had a duty to report changes in his earnings or earnings estimates and by failing to do so, he received an overpayment of benefits from SSA and the Court may enter an order, pursuant to 11 U.S.C. § 523(a)(2)(A), excepting from discharge in this and any future bankruptcy case the agreed-upon amount of \$19,664.40, plus interest at the statutory rate, as provided by 28 U.S.C. § 1961(a).

2. The Debtor stipulates and agrees to entry of a consent judgment against him on the non-discharged debt in the amount of \$19,664.40. Interest on the judgment shall accrue at the federal post-judgment interest rate then in effect on the date of judgment pursuant to 28 U.S.C. § 1961(a) and shall be computed daily and compounded annually until the judgment is paid in full,

but payment of interest shall be waived so long as the Debtor is not in default of this agreement or the terms of payment set forth herein.

3. Upon entry of the Order on this Stipulation, a Complaint for Judgment on Overpayment and a Stipulation for entry of a Consent Judgment in the amount of \$19,664.40 will be filed in the United States District Court for the District of Vermont that will provide for the stay of execution on the judgment and the payment agreement as further set forth in this Stipulation. The Debtor's bankruptcy counsel, Rebecca A. Rice, Esq., is authorized to waive personal service on the Debtor and accept service of the Complaint by First-Class Mail.

4. The Debtor hereby agrees to pay to SSA \$19,664.40, with interest at the federal post-judgment rate, in payments of at least \$50.00 per biweekly pay period (at least \$100.00 per month). The first post-judgment payment pursuant to this payment plan shall be due on December 15, 2018.

5. The parties agree that the monthly payment amount owed to SSA will be increased if and when the Debtor's ability to pay changes.

6. Within thirty (30) days of entry of the Court's Order on this Stipulation, the Debtor shall contact SSA directly at his local field office and make arrangements to remit monthly payments of at least \$50.00 per biweekly pay period directly to SSA beginning on December 15, 2018. Payments of at least \$50.00 per pay period shall be due on or before the 15th and last day of each month. Debtor shall make payments of at least \$100.00 each and every month until his debt is satisfied in full.

7. Unless otherwise agreed to by Debtor and SSA, pursuant to paragraph 6 of this Stipulation, the Debtor shall make his payments by check payable to the Social Security

Administration, annotated with his Social Security number, and sent to the following address:

Social Security Administration
MATPSC
P.O. Box 2861
Philadelphia, PA 19122-9985

8. If the Debtor becomes entitled to Social Security benefits now or in the future, SSA is entitled to automatically withhold Debtor's monthly payment from those benefits in lieu of Debtor's direct payments to SSA.

9. Payment of judgment interest shall be waived so long as the Debtor is not in default. Should the Debtor default, judgment interest shall be imposed from the date of the Order on this Stipulation at the rate in effect at the date the Order was entered. Judgment interest shall continue to accrue until the judgment is paid in full. In the event of default, the Debtor's payments, both prior and subsequent to default, will be applied first to accrued interest and then to judgment principal.

10. If the Debtor dies prior to fully satisfying his debt, SSA will have a claim against the Debtor's estate for the remaining amount owed to SSA, up to \$19,664.40, and the claim will have priority over other claims, pursuant to 31 U.S.C. § 3713, if there are insufficient assets in the estate to pay other claims.

11. In the event that the Debtor fails to make any timely monthly payments when due or fails to pay the debt in full as provided in paragraph 4 of this Stipulation, or fails to provide financial information upon request, the Debtor shall be in default on this Stipulation and agrees that interest at the statutory rate, as provided by 28 U.S.C. § 1961, shall be due and owing and subject to collection from the date of the Order on this Stipulation, and that the United States may

and shall be entitled to enforce and collect the judgment pursuant to the Federal Debt Collection Procedures Act and any other federal or state law, and to use any and all means of collection, including but not limited to wage garnishment, and offsets of federal tax refunds and other federal payments and benefits due the Debtor, to which the Debtor hereby consents.

12. In the event of default on this Stipulation and the filing of any action by the United States to enforce collection, the Debtor waives personal service and agrees that service may be completed by First-Class Mail upon his bankruptcy attorney, Rebecca A. Rice, Esq. The Debtor further agrees that he shall not raise or file any opposition to such collection efforts. It is further understood that in the event of default, as stated herein, the United States shall not be limited to its agreed-upon minimum monthly payment of \$100.00 and that the United States is free to collect the maximum amount allowable by law, including collection of all interest accrued from the date of the Order on this Stipulation, and to use any and all collection tools permitted by law.

13. If the Debtor defaults under the terms of this agreement and if Debtor receives any future Social Security benefits, SSA may withhold payments from any eligible benefits in lieu of the monthly payment described above during the period in which Debtor is paid Social Security benefits. Such payments or withholdings will be determined at a later date, and shall continue until the judgment amount has been satisfied.

14. The Debtor and SSA agree that the debt owed to SSA shall survive this bankruptcy case and any future voluntary bankruptcy case filed by the Debtor or involuntary bankruptcy case filed by the Debtor's creditors; the parties further agree that this debt, in the amount of \$19,664.40, plus interest, is and shall be non-dischargeable now and in the future. *See In re Frye*, 320 B.R. 786 (Bkrtcy. D. Vt. 2005) (pre-petition waiver of automatic stay found enforceable where, *inter*

alia, agreement was negotiated by parties represented by counsel were sufficiently sophisticated to understand implications of waiver, where enforcing agreement will encourage out of court settlements and the creditor would be prejudiced if the waiver is not enforced).

15. The Debtor may pay in full the outstanding balance at any time without penalty. Upon payment in full, the United States will file a satisfaction of judgment with the U.S. District Court and discharge all liens recorded by SSA against the Defendant's property.

16. This Stipulation constitutes the entire agreement and understanding of the Parties and may not be modified orally.

17. Each Party affirms to the other that they are represented by counsel in connection with this proceeding and this Stipulation, that the terms are agreeable to them and that they knowingly and freely concur in them and agree to be bound by them.

18. The Parties hereto consent to the entry of all orders and judgments necessary to effectuate this stipulation and agreement.

[Page 6 of Stipulation Ends Here; Signatures Follow on Page 7]

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Desc Main Document Page 7 of 7

Dated at Burlington, in the District of Vermont, this 3rd day of December, 2018.

Respectfully submitted,

UNITED STATES OF AMERICA

CHRISTINA E. NOLAN
United States Attorney

By: /s/ *Melissa A. D. Ranaldo*
MELISSA A.D. RANALDO
Assistant U.S. Attorney
P.O. Box 570
Burlington VT 05402-0570
(802) 951-6725
Melissa.Ranaldo@usdoj.gov

Attorney for the SOCIAL SECURITY
ADMINISTRATION

Dated at Rutland, in the District of Vermont, this 3rd day of December, 2018.

BERNARD FROST, Debtor
By His Attorney

E-CONSENT WILL BE FILED
REBECCA A. RICE, ESQ.
Attorney for Bernard Frost
26 West Street, Ste. 1
Rutland, VT 05701-3274
(802) 775-2352
steeplbush@aol.com

UNITED STATES BANKRUPTCY COURT
FOR THE
DISTRICT OF VERMONT

In Re:)
BERNARD FROST,) Bankruptcy No. 18-10289-cab
Debtor.) Chapter 7

UNITED STATES OF AMERICA,)
Plaintiff,) Adversary No. 18-01005-cab
v.)
BERNARD FROST,)
Defendant.)



**ORDER ON STIPULATION FOR CONSENSUAL SETTLEMENT OF
NON-DISCHARGEABILITY DISPUTE**

Upon consideration of and pursuant to the Stipulation for Consensual Settlement of Non-
Dischargeability Dispute filed by the United States of America and the Debtor, Bernard Frost, it
is hereby ORDERED that \$19,664.40 of the debt to the United States of America, Social Security
Administration, is hereby declared non-dischargeable pursuant to 11 U.S.C. § 523(a)(2)(A),
notwithstanding any order of discharge entered in the above-captioned Chapter 7 case. And it is
hereby FURTHER ORDERED that the United States is free to seek a civil judgment against the
Debtor in the amount of \$19,664.40 and may enforce such judgment in accordance with the
agreement of the parties. Interest on any judgment entered shall also be non-dischargeable. ^{**}

IT IS FURTHER ORDERED the hearing set for December 5, 2018 is canceled.

HON. COLLEEN A. BROWN
United States Bankruptcy Judge

** IT IS FURTHER ORDERED the other provisions of the parties' settlement, as fully described in the
Stipulation filed On December 3, 2018 (doc. # 11), are hereby approved in their entirety.

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS

United States of America

DEFENDANTS

Bernard Frost

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)County of Residence of First Listed Defendant Bennington County
(IN U.S. PLAINTIFF CASES ONLY)NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF
THE TRACT OF LAND INVOLVED.(c) Attorneys (Firm Name, Address, and Telephone Number)
Melissa A.D. Ranaldo, AUSA, U.S. Attorney's Office, P.O. Box 570,
Burlington, VT 05402, (802) 951-6725Attorneys (If Known)
Rebecca A. Rice, Esq., 26 West Street, Ste. 1, Rutland, VT
05701-3274, (802) 775-2352

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

<input checked="" type="checkbox"/> 1 U.S. Government Plaintiff	<input type="checkbox"/> 3 Federal Question (U.S. Government Not a Party)
<input type="checkbox"/> 2 U.S. Government Defendant	<input type="checkbox"/> 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)

	PTF	DEF	PTF	DEF
Citizen of This State	<input type="checkbox"/> 1	<input type="checkbox"/> 1	Incorporated or Principal Place of Business In This State	<input type="checkbox"/> 4 <input checked="" type="checkbox"/> 4
Citizen of Another State	<input type="checkbox"/> 2	<input type="checkbox"/> 2	Incorporated and Principal Place of Business In Another State	<input type="checkbox"/> 5 <input checked="" type="checkbox"/> 5
Citizen or Subject of a Foreign Country	<input type="checkbox"/> 3	<input type="checkbox"/> 3	Foreign Nation	<input type="checkbox"/> 6 <input checked="" type="checkbox"/> 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT	TORTS	FORFEITURE/PENALTY	BANKRUPTCY	OTHER STATUTES
<input type="checkbox"/> 110 Insurance	PERSONAL INJURY	PERSONAL INJURY	<input type="checkbox"/> 425 Drug Related Seizure of Property 21 USC 881	<input type="checkbox"/> 375 False Claims Act
<input type="checkbox"/> 120 Marine	<input type="checkbox"/> 310 Airplane	<input type="checkbox"/> 365 Personal Injury - Product Liability	<input type="checkbox"/> 422 Appeal 28 USC 158	<input type="checkbox"/> 400 State Reapportionment
<input type="checkbox"/> 130 Miller Act	<input type="checkbox"/> 315 Airplane Product Liability	<input type="checkbox"/> 367 Health Care/ Pharmaceutical Personal Injury Product Liability	<input type="checkbox"/> 423 Withdrawal 28 USC 157	<input type="checkbox"/> 410 Antitrust
<input type="checkbox"/> 140 Negotiable Instrument	<input type="checkbox"/> 320 Assault, Libel & Slander	<input type="checkbox"/> 368 Asbestos Personal Injury Product Liability		<input type="checkbox"/> 430 Banks and Banking
<input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment	<input type="checkbox"/> 330 Federal Employers' Liability			<input type="checkbox"/> 450 Commerce
<input type="checkbox"/> 151 Medicare Act	<input type="checkbox"/> 340 Marine			<input type="checkbox"/> 460 Deportation
<input type="checkbox"/> 152 Recovery of Defaulted Student Loans (Excludes Veterans)	<input type="checkbox"/> 345 Marine Product Liability			<input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations
<input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits	<input type="checkbox"/> 350 Motor Vehicle	<input type="checkbox"/> 370 Other Fraud		<input type="checkbox"/> 480 Consumer Credit
<input type="checkbox"/> 160 Stockholders' Suits	<input type="checkbox"/> 355 Motor Vehicle	<input type="checkbox"/> 371 Truth in Lending		<input type="checkbox"/> 490 Cable/Sat TV
<input type="checkbox"/> 190 Other Contract	<input type="checkbox"/> 360 Other Personal Injury	<input type="checkbox"/> 380 Other Personal Property Damage		<input type="checkbox"/> 850 Securities/Commodities/ Exchange
<input type="checkbox"/> 195 Contract Product Liability	<input type="checkbox"/> 362 Personal Injury - Medical Malpractice	<input type="checkbox"/> 385 Property Damage Product Liability		<input checked="" type="checkbox"/> 890 Other Statutory Actions
<input type="checkbox"/> 196 Franchise				<input type="checkbox"/> 891 Agricultural Acts
REAL PROPERTY	CIVIL RIGHTS	PRISONER PETITIONS	SOCIAL SECURITY	<input type="checkbox"/> 893 Environmental Matters
<input type="checkbox"/> 210 Land Condemnation	<input type="checkbox"/> 440 Other Civil Rights	Habeas Corpus:	<input type="checkbox"/> 861 HIA (1395ff)	<input type="checkbox"/> 895 Freedom of Information Act
<input type="checkbox"/> 220 Foreclosure	<input type="checkbox"/> 441 Voting	<input type="checkbox"/> 463 Alien Detainee	<input type="checkbox"/> 862 Black Lung (923)	<input type="checkbox"/> 896 Arbitration
<input type="checkbox"/> 230 Rent Lease & Ejectment	<input type="checkbox"/> 442 Employment	<input type="checkbox"/> 510 Motions to Vacate Sentence	<input type="checkbox"/> 863 DIWC/DIWW (405(g))	<input type="checkbox"/> 899 Administrative Procedure
<input type="checkbox"/> 240 Torts to Land	<input type="checkbox"/> 443 Housing/ Accommodations	<input type="checkbox"/> 530 General	<input type="checkbox"/> 864 SSID Title XVI	Act/Review or Appeal of Agency Decision
<input type="checkbox"/> 245 Tort Product Liability	<input type="checkbox"/> 445 Amer. w/Disabilities - Employment	<input type="checkbox"/> 535 Death Penalty	<input type="checkbox"/> 865 RSI (405(g))	<input type="checkbox"/> 950 Constitutionality of State Statutes
<input type="checkbox"/> 290 All Other Real Property	<input type="checkbox"/> 446 Amer. w/Disabilities - Other	Other:		
	<input type="checkbox"/> 448 Education	<input type="checkbox"/> 540 Mandamus & Other		
		<input type="checkbox"/> 550 Civil Rights		
		<input type="checkbox"/> 555 Prison Condition		
		<input type="checkbox"/> 560 Civil Detainee - Conditions of Confinement		
		IMMIGRATION	FEDERAL TAX SUITS	
		<input type="checkbox"/> 462 Naturalization Application	<input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant)	
		<input type="checkbox"/> 465 Other Immigration Actions	<input type="checkbox"/> 871 IRS—Third Party 26 USC 7609	

RECEIVED

DEC - 7 2018

U.S. DISTRICT COURT
BURLINGTON, VT

V. ORIGIN (Place an "X" in One Box Only)

<input checked="" type="checkbox"/> 1 Original Proceeding	<input type="checkbox"/> 2 Removed from State Court	<input type="checkbox"/> 3 Remanded from Appellate Court	<input type="checkbox"/> 4 Reinstated or Reopened	<input type="checkbox"/> 5 Transferred from Another District (specify) _____	<input type="checkbox"/> 6 Multidistrict Litigation
---	---	--	---	--	---

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
42 U.S.C. Section 404

VI. CAUSE OF ACTION

Brief description of cause:
recover overpayment of SSA benefits

VII. REQUESTED IN COMPLAINT:

 CHECK IF THIS IS A CLASS ACTION
UNDER RULE 23, F.R.Cv.P.DEMAND \$
19,664.40CHECK YES only if demanded in complaint:
JURY DEMAND: Yes No

VIII. RELATED CASE(S) IF ANY

(See instructions):

JUDGE

DOCKET NUMBER

DATE 12/7/18

SIGNATURE OF ATTORNEY OF RECORD

Melissa Ranaldo / by NPK

FOR OFFICE USE ONLY

RECEIPT #

AMOUNT

APPLYING IFP

JUDGE

1013

MAG. JUDGE

5:18-cv-212